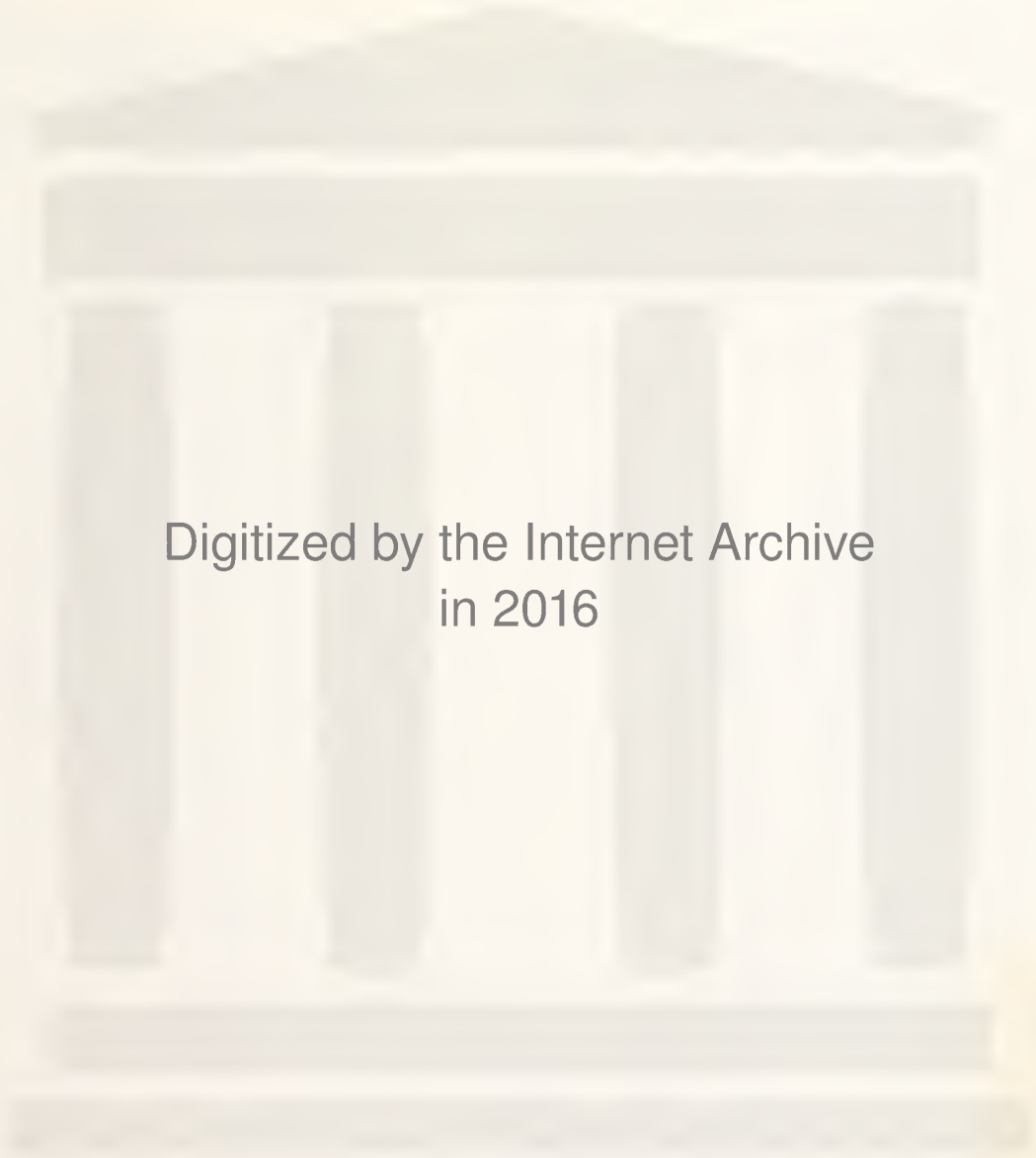

Digitized by the Internet Archive
in 2016

https://archive.org/details/journalofindiana612unse

Vol. 61 • No. 7
July, 1968

The JOURNAL

OF THE INDIANA STATE MEDICAL ASSOCIATION
Indianapolis, Indiana

J-O-P
Univ. Of Calif
Med Ctr Library
Acquisitions Dept
San Francisco, Ca

U.C. MEDICAL CENTER LIBRARY
AUG 5 1968
San Francisco 94122
234863

The AMBAR SCRAPBOOK of Obesity Oddities
FACT & LEGEND

CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg.,
phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety... helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY,
RICHMOND, VA. 23220

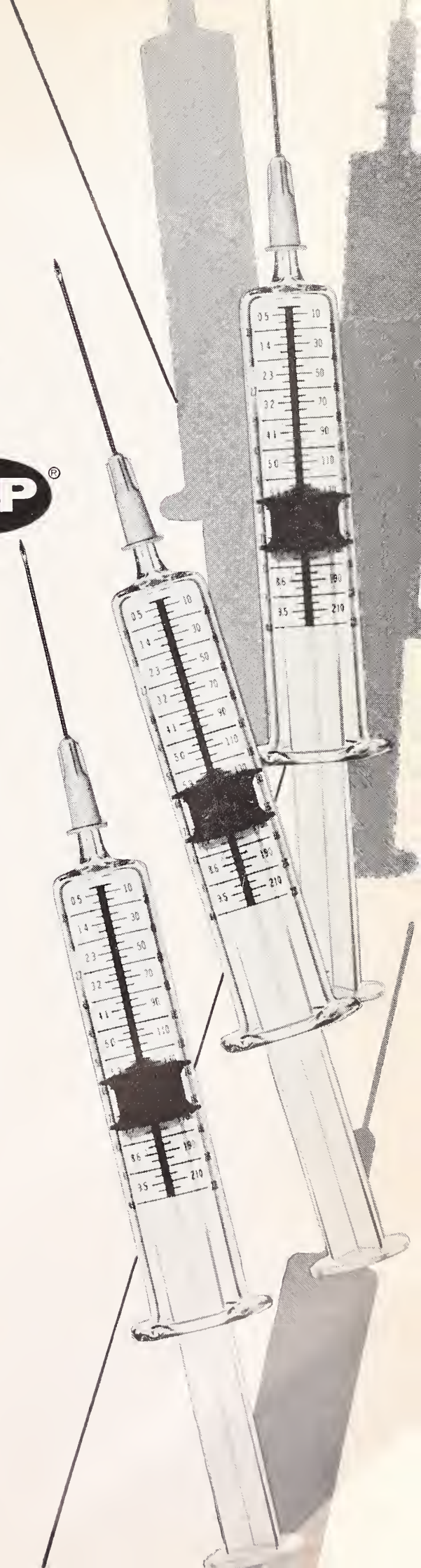
A·H·ROBINS

BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)

BSP®



BROMSULPHALEIN®

IN A COMPLETE,

STERILE,

DISPOSABLE,

& ECONOMICAL

PATIENT-UNIT.

BSP, one of the more valuable single laboratory procedures for determining hepatic function, is now packaged in a complete individual patient-unit.

Each BSP Disposable Unit contains a sterile syringe with the 5 mg./kg. BSP dosage schedule imprinted on the barrel, a sterile needle, alcohol swab and a 7.5 ml. or 10 ml. size ampule of terminally sterilized Bromsulphalein solution.

This all-inclusive disposable put-up lessens the chance of cross-infection and saves time and labor— the most costly commodities.

HYNSON, WESTCOTT & DUNNING, INC.

HW&D (BSP03)

BALTIMORE, MARYLAND 21201

JULY 1968

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Office of Publication

3935 N. Meridian, Indianapolis, Indiana 46208

Contents

SCIENTIFIC

Significance of the Pale, Boggy Nasal Mucosa, Irvin Caplin, M.D., John T. Haynes, M.D., Duane Houser, M.D., Indianapolis 981

Comparison of the Mono Test and the Heterophile Antibody Test, H. T. Russell, M.D., W. F. Ricchetti, M.D., Edith Carlson, M.T. (ASCP), Lafayette 984

Ovulation Induction with Clomiphene Citrate, Charles R. Echt, M.D., Jerry A. Goodman, A.B., Indianapolis 986

Endometriosis in a Case of Primary Hypogonadism, A. W. Cavins, M.D., Terre Haute 996

Management of Acne Vulgaris, Victor C. Hackney, M.D., Indianapolis 1000

Clinicopathologic Conference, Charles Fisch, M.D., Frank Vellios, M.D., Garry L. Bolinger, M.D., Indianapolis 1002

X-Ray Conference: Bicornuate Uterus with Hypoplasia of Right Anlage, Erich K. Lang, M.D., Shreveport, La. 1013

Electrocardiogram of the Month, Charles Fisch, M.D., Indianapolis 1023

Path-Finder: What's Your Diagnosis? Wei-Ping Loh, M.D., Gary 1024

The Cancer You View, John G. Pantzer, M.D., Indianapolis 1026

EDITORIALS

Pharmaceutical Industry Research 1028

Indiana School and Community Health Workshop 1028

Plastic Surgery: Reconstructive or Cosmetic?, James E. Bennett, M.D., Indianapolis .. 1029

Editorial Notes 1030

SPECIAL FEATURES

The Sophist Society, Arthur G. Blazey, M.D., Washington 1036

REGULAR FEATURES

What's New? 965

Month in Washington 966

Fourth Estate 972

Letters to the Editor 978

Correspondence 978

President's Page 1032

The Woman's Auxiliary Reports to ISMA 1034

Day by Day With the F.D.A. 1038

Medicine At Law 1040

Changes in Blue Shield Prepayment Patterns (One of a Series) 1049

Wanted: Physicians, Locations 1049

Abstracts, Book Reviews 1052

From The Journal 50 Years Ago 1056

News Notes 1058

Annual Meeting Dates of Professional Medical and Allied Organizations 1061

Future Meetings, Seminars, Courses 1062

County, District News 1064

Deaths 1065

Board of Health Report 1066

BUSINESS

Executive Committee: April 7, 1968 1068

Council: March 8, 1968 1069

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 46202. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

Representative for national advertising is the State Medical Journal Advertising Bureau, 510 N. Dearborn St., Chicago, Ill.

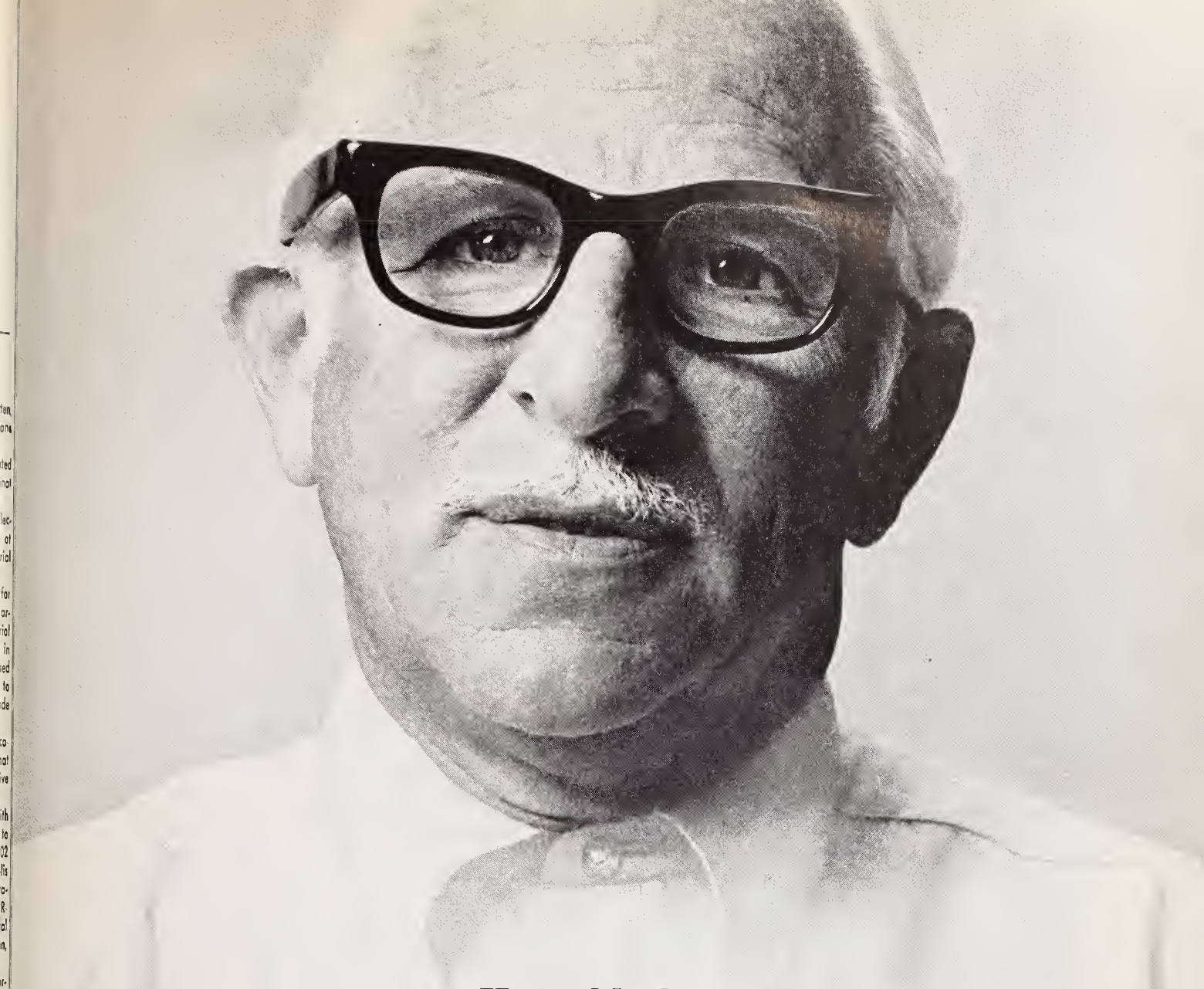
Entered as second class matter January 25, 1933, at the Postoffice at Indianapolis, Indiana. Copyright, 1968 by the Indiana State Medical Association. Published monthly at 3935 N. Meridian, Indianapolis 46208.

Second-class postage paid at Indianapolis, Indiana and at additional mailing office.

All issues of 1967 and subsequently may be obtained on microfilm. Address The Journal for details.

About Our Cover

on page 990.



He is elderly, he is on corticosteroids, when he needs an antibiotic he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units CAPSULE-SHAPED TABLETS Lederle

b.i.d.

o guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of ystatin is combined with demethylchlortetracycline in ECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN the broad-spectrum therapy that prevents monilial vergrowth.

ontraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

arning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses re indicated, and, if therapy is prolonged, serum level determinations ay be advisable. A photodynamic reaction to natural or artificial sunght has been observed. Small amounts of drug and short exposure may roduce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct xposure to sunlight and discontinue drug at the first evidence of skin iscomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

recautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken.

In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, fo and some dairy products. Treatment of streptococcal infections sh continue for 10 days, even though symptoms have subsided.

LEDERLE LABORATORIES, A Division of American Cyanamid Co Pearl River, New York

THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545

ANNUAL CONVENTION—OCTOBER 15-18, 1968—FORT WAYNE

OFFICERS FOR 1967-68

President—G. O. Larsan, M.D., 1110 Indiana Ave., LaParte 46350.

President-Elect—Patrick J. V. Carcaran, 3700 Bellemeade, Evansville 47715.

Treasurer—Lester H. Hayt, M.D., Methadist Haspital, Indianapalis 46207.

Assistant Treasurer—Malcalm O. Scamaharn, Pittsbara 46167.

Executive Secretary—Mr. James A. Waggener, 3935 N. Meridian, Indianapalis 46208.

COUNCILORS

District	Term Expires
1—Gilbert M. Wilhelmus, Evansville	Oct. 1968
2—Jae Dukes, Dugger	Oct. 1969
3—Danald M. Kerr, Bedfard	Oct. 1970
4—Rabert M. Reid, Calumbus	Oct. 1968
5—Wilbert McIntash, Riley	Oct. 1969
6—Stephen D. Smith, Knightstawn	Oct. 1970
7—Albert M. Danata, Indianapalis	Oct. 1968
8—Danald R. Taylar, Muncie	Oct. 1969
9—Peter R. Petrich, Attica	Oct. 1970
10—Lawell H. Steen, Whiting (Chairman)	Oct. 1968
11—Lawell Hillis, Laganspart	Oct. 1969
12—William R. Clark, Fart Wayne	Oct. 1970
13—Otis R. Bawen, Bremen	Oct. 1968

ALTERNATE COUNCILORS

District	Term Expires
1—Eugene Austin, Evansville	1970
2—Betty Dukes, Dugger	1968
3—Elmer L. Wallace, New Albany	1968
4—Jack E. Shields, Brownstawn	1970
5—Clean M. Schauwecker, Greencastle	1970
6—Frank Green, Rushville	1969
7—Jahn O. Butler, Indianapalis	1969
8—Paul Sparks, Winchester	1970
9—Clarence G. Kern, Lebanan	1968
10—Herman Wing, Gary	1969
11—James A. Harshman, Kakama	1968
12—Frederic L. Schaen, Fart Wayne	1970
13—Gearge B. Gattman, Elkhart	1970

SECTION OFFICERS 1967-68

Section an Surgery:
Chairman—Danald M. Schlegel, Indianapalis
Vice-chairman—Henry Larzelere, Marian
Secretary—Austin Gardner, Indianapalis

Sectian an Internal Medicine:
Chairman—I. E. Michael, Indianapalis
Vice-chairman—Lauis Sandack, Sauth Bend
Secretary—Rabert L. Rudesill, Indianapalis

Sectian an Ophthalmalagy and Otalaryngalagy:
Chairman—M. Richard Harding, Indianapalis
Vice-chairman—Francis W. Parker, Laganspart
Secretary—Gearge A. Clark, Indianapalis

Sectian on Anesthesialagy:
Chairman—William M. Matthews, Indianapalis
Vice-chairman—Merle E. Pickett, Fart Wayne
Secretary—Jerry R. Miller, Indianapalis

Sectian an General Practice:
Chairman—Jay S. Reese, Martinsville
Vice-chairman—Rabert Mauser, Indianapalis
Secretary—Richard Juergens, Fart Wayne

Sectian an Obstetrics and Gynecalagy:
Chairman—Rabert M. Reid, Calumbus
Vice-chairman—Tam W. Wachab, Jr., Kakama
Secretary—Charles R. Echt, Indianapalis

Sectian an Public Health and Preventive Medicine:
Chairman—Danald M. Kerr, Bedfard
Vice-chairman—T. Neal Petry, Delphi
Secretary—Henry G. Nester, Indianapalis

Sectian an Radialagy:
Chairman—Richard A. Silver, Indianapalis
Vice-chairman—Jahn A. Rabb, Indianapalis
Secretary—Edwin F. Kach, Jr., Muncie

Sectian an Nervaus and Mental Diseases.
Chairman—Gardan T. Brawn, Indianapalis
Vice-chairman—James E. Bensan, Elkhart
Secretary—Wesley A. Kissel, Indianapalis

Sectian on Pathalagy:
Chairman— Rabert J. Frast, Michigan City
Vice-chairman—
Secretary—Rabert L. Castin, Indianapalis

Sectian an Pediatrics:
Chairman—Raland E. Miller, Lafayette
Vice-chairman—Gustaf W. Ericksan, Sauth Bend
Secretary—Marris Green, Indianapalis

DELEGATES TO THE AMA

Terms expire December 31, 1968:

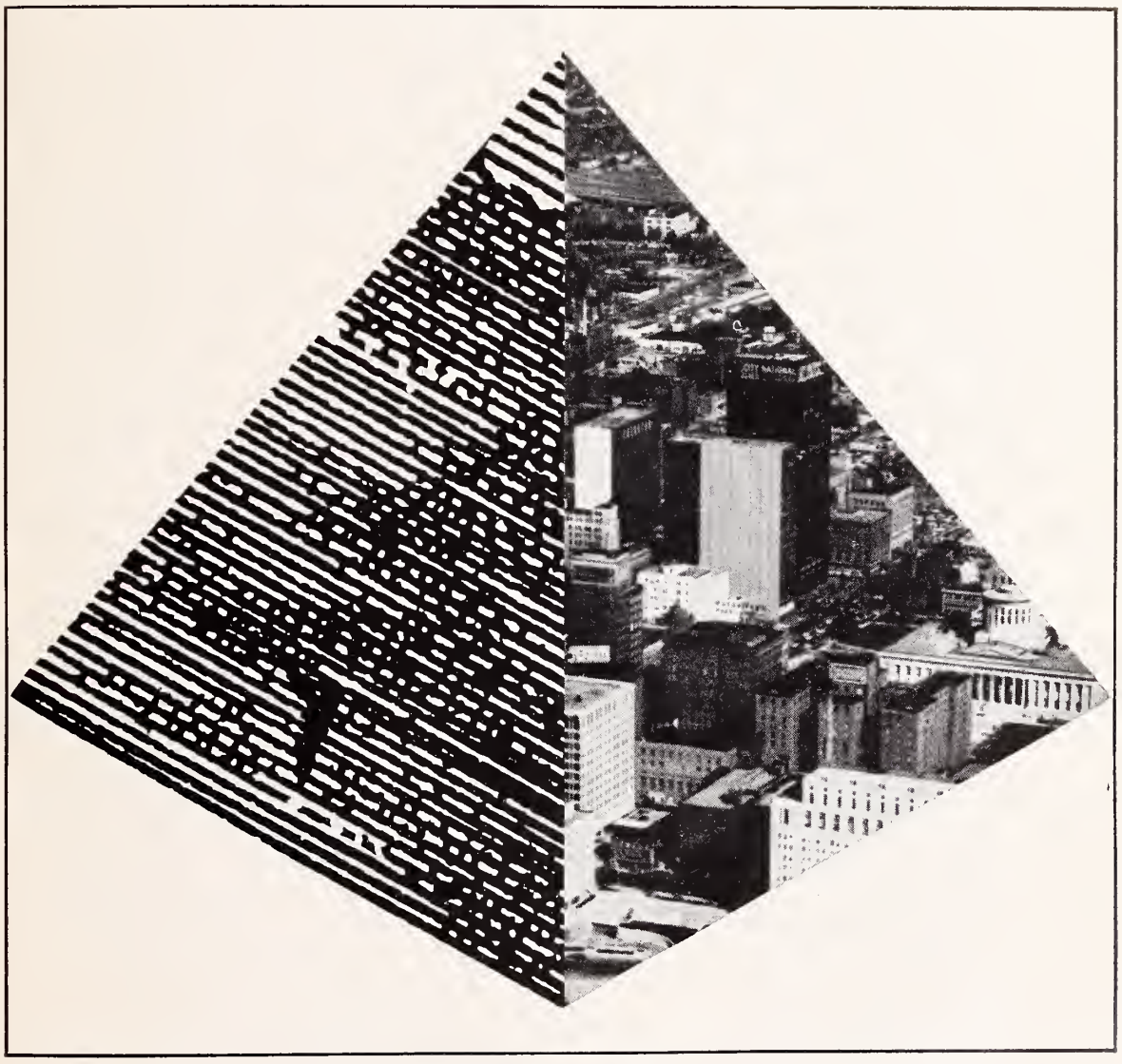
Delegates	Alternates
Harald C. Ochsner Indianapalis	Dan E. Waad Indianapalis
Eugene F. Senseny Fart Wayne	Rabert M. Brawn Marian
Frank H. Green Rushville	Kenneth O. Neumann Lafayette

Terms expire December 31, 1969:

Delegates	Alternates
Guy A. Owsley Hartford City	Maurice E. Glack Fart Wayne
Jack E. Shields Brawnstown	Dwight W. Schuster Indianapalis

In the twinkling of an eye...

I Corinthians XV, 52 (circa 55 A.D.)



Just how *quick* is the "twinkling of an eye"? The expression originated in the New Testament where it was used to describe the suddenness of the end of the world. In fabledom, a fairy godmother twinkled her eye, waved a wand, and changed pumpkin and mice into an elegant coach with full crew. And by flipping through the pages of history, you can leap from the pyramids of Ancient Egypt into Today . . . in the twinkling of an eye.

Across the past 67 years, White-Haines has established an enviable reputation as a leading supplier of ophthalmic products and services. The reason can be demonstrated very quickly. Let's put it this way: in the *twinkling* of an eye, we'll put a *sparkle* in yours . . . and in the eyes of those who depend on *you*.

THE WHITE-HAINES OPTICAL COMPANY
Headquarters: Columbus, Ohio
Serving Ohio • Michigan • Pennsylvania
West Virginia • Kentucky
Indiana • Illinois • Maryland

COUNTY MEDICAL SOCIETY DIRECTORY

COUNTY	PRESIDENT	SECRETARY
Adams	Arthur H. Girod, Decatur	Harold F. Zwick, 227 S. Second St., Decatur
Allen (Fort Wayne)	Frederic L. Schoen, Fort Wayne	Eugene E. Schmidt, Suite 725, Indiana Bank Bldg., Fort Wayne
		Mr. Larry L. Pickering, Exec. Secy., 212 Med. Ctr. Bldg., Fort Wayne
Bartholomew-Brown	Harold W. Richmond, Columbus	C. David Ryan, 2600 Sandcrest Blvd., Columbus
Benton	A. L. Coddens, Earl Park	D. L. McKinney, Box 398, Otterbein
Boone	James R. McAfee, Lebanon	Katherine A. Jackson, 95 E. Oak St., Zionsville
Carroll	Marilyn L. Wagoner, Burlington	Robert Seese, 101 W. North St., Delphi
Cass	Joseph S. Bean, Logansport	Edward L. TerBush, 216 Ninth Street, Logansport
Clark	Robert K. McKechnie, Jeffersonville	Hassi Shina, Charlestown
Clay	J. Frank Maurer, Brazil	Forrest R. Buell, 314 Lankford St., Clay City
Clinton	Bruce A. Work, Frankfort	George K. Hammersley, 361 E. Clinton St., Frankfort
Daviess-Martin	A. G. Blazey, Washington	Hamlin B. Lindsay, 511 E. Main St., Washington
Dearborn-Ohio	Fred D. Houston, Lawrenceburg	Leslie M. Baker, 501 Fourth St., Aurora
Decatur	Dale D. Dickson, Greensburg	Arnold D. Ducanes, 215 N. Franklin St., Greensburg
DeKalb	John C. Harvey, Auburn	C. Bishop Hathaway, 209 N. Jackson St., Auburn
Delaware-Blackford	Glynn A. Rivers, Muncie	Richard N. Philbert, 2810 Ethel Ave., Muncie
Dubois	John P. Salb, Jasper	Edward Ploetner, 111-115 Central Bldg., Jasper
Elkhart	Philip G. Bowser, Goshen	Page E. Spray, 320 W. High St., Elkhart
Fayette-Franklin	B. W. Sanders, Connersville	J. L. Steinem, 818 Grand Ave., Connersville
Floyd	James Y. McCullough, New Albany	Daniel H. Cannon, 1201 E. Spring St., New Albany
Fountain-Warren	Max N. Hoffman, Covington	Theodore Person, 601 N. Mill St., Veedersburg
Fulton	Joseph D. Richardson, Rochester	F. Richard Walton, 116 W. 9th St., Rochester
Gibson	William E. Dye, Oakland City	David H. Lindauer, 115 N. Prince St., Princeton
Grant	J. C. Jarrett, Marion	Robert G. Young, 1207 Northwood Ct., Marion
Greene	Robert Moses, Worthington	Harry Rotman, Jasonville
Hamilton	John S. Hash, Noblesville	H. R. Blackburn, Riverview Hospital, Noblesville
Hancock	John J. Farrell, Greenfield	Joseph A. Miller, Oaklandon
Harrison-Crawford	Carl Dillman, Corydon	Richard A. Jordan, Corydon
Hendricks	Eli Coats, Indianapolis	Carl J. Heinlein, 637 E. Main, Danville
Henry	John E. Fisher, New Castle	Phyllis Grant, 3007 S. 14th St., New Castle
Howard	Robert L. Michael, Kokomo	J. F. Doss, 3520 Lafountain, Kokomo
Huntington	Barth E. Wheeler, Huntington	Carl S. Ray, Warren
Jackson-Jennings	Kenneth E. Bobb, Seymour	William F. Blaisdell, 207 N. Pine, Seymour
Jasper	Ernest R. Beaver, Rensselaer	Francis E. O'Brien, McKinley and Washington Sts., Rensselaer
Jay	Ralph Steffy, Portland	Elizabeth Tate, 317 S. Main St., Dunkirk
Jefferson-Switzerland	Elton Heaton, Madison	Ott B. McAtee, Madison State Hospital, Madison
Johnson	George Brown, Greenwood	Charles Link, 365 E. Main St., Greenwood
Knox	Boyd K. Black, Vincennes	John S. Murray, 317 Security Bank Bldg., Vincennes
Kosciusko	Wymond B. Wilson, Mentone	Arthur L. Moser, 600 Winona, Warsaw
LaGrange	Michael O. Mellinger, LaGrange	Allen S. Martin, Box 3A, Shipshewana
Lake	Seymour W. Shapiro, Gary	Reginald R. Barton, 7737 Forrest Ave., Gary
		Mr. John B. Twyman, Ex. Dir., 4640 W. 5th Ave., Gary
LaPorte	William E. Wolf, LaPorte	James J. J. Sprecher, 1001 Maple Ave., LaPorte
		Mrs. Polly Dent, Exec. Dir., 903 Indiana Ave., LaPorte
Lawrence	George W. Sorrells, Bedford	Reid C. Crosby, 11 Saddler Ct., Bedford
Madison	John R. Wagoner, Anderson	William M. Stinson, 333 Jackson St., Anderson
Marion	Dwight W. Schuster, Indianapolis	John O. Butler, 234 E. Southern Ave., Indianapolis
		Mr. Arthur G. Loftin, Exec. Secy., 2902 N. Meridian, Indianapolis
Marshall	John K. Guild, Plymouth	M. George Rosero, Kewanna
Miami	Parker W. Snyder, Peru	Gordon S. Crates, Denver
Montgomery	V. G. Viray, Crawfordsville	W. E. Shannon, 408 W. Market St., Crawfordsville
Morgan	George Ostheimer, Martinsville	Maurice A. Turner, 10½ N. Main St., Martinsville
Newton	John Parker, Goodland	Arthur Schoonveld, Brook
Noble	O. Thomas Slough, Kendallville	Joseph Greenlee, Avilla
Orange	Charles X. McCalla, Paoli	Phillip T. Hodgin, Orleans
Owen-Monroe	Brad Bomba, Bloomington	Philip R. Karsell, 3901 E. 3rd St., Bloomington
Parke-Vermillion	John Somerville, Clinton	Milton Herzberg, Clinton
Perry	Robert Gilbert, Tell City	Gene E. Ress, 507 Main St., Tell City
Pike	M. H. Omstead, Petersburg	M. H. Omstead, Petersburg
Porter	John E. Read, Chesterton	Milton R. Carlson, 14000 Central, Portage
Posey	Paul Boren, Poseyville	Herman Hirsch, 130 W. 5th St., Mt. Vernon
Pulaski	Henry R. Eshelman, Monterey	E. L. Hollenberg, 613 Tippecanoe Dr., Winamac
Putnam	James B. Johnson, Greencastle	Anne S. Nichols, 707 E. Seminary, Greencastle
Randolph	Howard W. Koch, Winchester	Paul W. Sparks, 214 S. Main St., Winchester
Ripley	Bill E. Freeland, Batesville	William J. Warn, Milan
Rush	Donald I. Dean, Rushville	Charles E. Sheets, Manilla
St. Joseph	Jacob Rosenwasser, Mishawaka	L. F. Sandock, 503 Sherland Bldg., South Bend
		Mr. Harry Davis, Exec. Secy., 106 W. Monroe, South Bend
Scott	Ignacio B. Castro, Shelbyville	Jesus C. Bacala, 69 Wardell St., Scottsburg
Shelby	P. M. Inlow, Shelbyville	R. P. Inlow, 103 W. Washington St., Shelbyville
Spencer	John C. Glackman, Jr., Rockport	Michael O. Monar, Rockport
Starke	Earl Leinbach, Hamlet	W. Allen Palmer, Knox
Steuben	Mary H. Cameron, Angola	Richard W. Artz, 416 E. Maumee St., Angola
Sullivan	Glen McClure, Sullivan	J. S. Brown, Carlisle
Tippecanoe	L. H. Wagner, Lafayette	Chester L. Waits, 49 N. 26th St., Lafayette
Tipton	Robert L. Haller, Kempton	Albert E. Stouder, Kempton
Vanderburgh	Ralph Carlson, Evansville	Mr. Arthur P. Tiernan, Exec. Secy., 109½ S. E. 3rd., Evansville
Vigo	John Freed, Terre Haute	Robert L. Meissel, 920 N. 19th St., Terre Haute
Wabash	Fred C. Poehler, LaFontaine	Frank Smyrniotis, 645 Spring St., Wabash
Warrick	Peter B. Hoover, Boonville	Robert C. Colvin, Newburgh
Washington	Eddie R. Apple, Salem	Truman L. Chastain, 906 W. Mulberry, Salem
Wayne-Union	John Stepleton, Richmond	John Dehner, Reid Memorial Hospital, Richmond
Wells	Charles Caylor, Bluffton	R. D. Willard, R. R. 4, Bluffton
White	W. M. Dickerson, Monticello	M. Ali Jehanyar, 116 N. Illinois, Monticello
Whitley	Verlin P. Huffman, S. Whitley	Thomas Hamilton, 115 S. Main St., Columbia City

The Arthritis Foundation salutes the thousands of dedicated physicians who volunteer their services in the nation's fight against crippling arthritis.

The Arthritis Foundation is the sole national voluntary health agency committed to conquering the rheumatic diseases. It provides the means for dynamic partnership between physicians and laymen to marshal leadership and resources toward the solution of this major national health problem.

The Arthritis Foundation looks forward to rapid growth with increasing opportunity for physicians to participate in the arthritis movement. For further information about The Arthritis Foundation and its programs write to the Foundation chapter in your community or to the Medical Department, Box 2525, New York, N.Y. 10001.

Floyd B. Odlum
Chairman of the Board

William S. Clark, M.D.
President

Donald F. Hill, M.D.
President of the American
Rheumatism Association Section

William E. Reynolds, M.D.
Medical Director

ISMA Committees and Commissions for 1967–1968

COMMITTEES

Executive

Ralph V. Everly, Indianapolis, chairman; Burton E. Kintner, Elkhart; G. O. Larson, LaPorte, President; Patrick J. V. Corcoran, Evansville, President-Elect; Lowell H. Steen, Whiting, Chairman of the Council; Lester H. Hoyt, Indianapolis, Treasurer; Malcolm O. Scamahorn, Pittsboro, Assistant Treasurer.

Grievance

Philip B. Reed, Indianapolis, chairman; Eugene S. Rifner, Van Buren, vice-chairman; Robert G. Young, Marion, secretary; Kenneth L. Olson, South Bend, Earl W. Mericle, Indianapolis; Richard Bloomer, Rockville; John M. Paris, New Albany; Wilson L. Dalton, Shelbyville; William R. Noe, Bedford.

Student Loan

G. O. Larson, LaPorte; Lester H. Hoyt, Indianapolis; Glenn W Irwin, Indianapolis; Donald R. Taylor, Muncie; James O. Ritchey, Indianapolis; Lester D. Bibler, Indianapolis; Mr. Robert Robinson, Indianapolis.

Medical-Legal Review

Lall G. Montgomery, Muncie; Truman E. Caylor, Bluffton; E Rogers Smith, Indianapolis

COMMISSIONS

Aging

George M. Young, Gary, Chairman; A. W. Cavins, Terre Haute, Vice-Chairman; Raymond Duncan, Bedford, Secretary; Bernard B. Rosenblatt, Evansville; R. E. Buckingham, Bloomington; Walter S. Fisher, Columbus; Glen A. Ramsdell, Richmond; John O. Butler, Indianapolis; John Cullison, Muncie; Wallace R. Van Den Bosch, Lafayette; George W. Wagoner, Delphi; Nathan Salon, Fort Wayne; Donald T. Olson, South Bend; Andrew C. Offutt, Indianapolis; Wendell C. Anderson, Indianapolis.

Constitution and Bylaws

Gordon S. Fessler, Rising Sun, Chairman; William M. Sholty, Lafayette, Vice-Chairman; James F. Lewis, Liberty, Secretary; George W. Willison, Evansville; Thomas H. Gootee, Jasper; M. C. Topping, Terre Haute; Joseph F. Ferrara, Franklin; B. D. Wagoner, Union City; Chester L. Waits, Lafayette; O. L. Marks, East Chicago; Richard L. Glendening, Logansport; John S. Farquhar, Fort Wayne; Edwin C. Mueller, La Porte; Burton Kintner, Elkhart.

Convention Arrangements

Charles H. Aust, Fort Wayne, Chairman; Durward W. Paris, Kokomo, Vice-Chairman; William M. Kendrick, Mooresville, Secretary; Richard B. Hovda, Evansville; William F. Howard, Bloomington; Irvin Sonne, New Albany; Merritt O. Alcorn, Madison; John E. Freed, Jr., Terre Haute; John Mader, Richmond; Francis E. Stout, Muncie; Boyd A. Burkhardt, Tipton; John L. Ferry, Whiting; James D. Finfrock, Elkhart; Kenneth Kohlstaedt, Indianapolis; Charles Fisch, Indianapolis.

Governmental Medical Services

Charles Hendrix, Vincennes; Guy H. Waldo, Bedford; Herman Echsner, Columbus; Dick J. Steele, Greencastle; Tom S. Shields, Richmond; Robert P. Scott, Indianapolis; J. F. Hinchman, Parker; Ramon B. Dubois, Lafayette; Edward J. Dierolf, Gary; George D. Buckner, Fort Wayne; D. D. Swihart, Elkhart; Jerome E. Holman, Jr., Indianapolis; Glen V. Ryan, Indianapolis.

Inter-Professional Relations

Fred Flora, Frankfort, Chairman; Virgil E. Angel, Highland, Vice-Chairman; William S. Robertson, Spiceland, Secretary; A. Wayne Ratcliffe, Evansville; Philip R. Karsell, Bloomington; Charles X. McCalla, Paoli; John W. Ripley, Seymour; Richard L. Veach, Bainbridge; Willis W. Stogsdill, Indianapolis; Wendell Covalt, Muncie; H. H. Dunham, Wabash; Pierre C. Talbert, Bluffton; A. Alan Fischer, Indianapolis; Robert G. Husted, Munster.

Legislation

Dwight W. Schuster, Indianapolis, Chairman; Don E. Wood, Indianapolis, Vice-Chairman; Jack W. Hickman, Indianapolis, Secretary; Daniel M. Hare, Evansville; Harold Manifold, Bloomington; Elmer L. Wallace, New Albany; Leslie M. Baker, Aurora; Fred W. Dierdorf, Terre Haute; John Davis, Flat Rock; Guy A. Owsley, Hartford City; Max N. Hoffman, Covington; Daniel Ramker, Hammond; Lester Renbarger, Marion; Eugene F. Senseny, Fort Wayne; Otis R. Bowen, Bremen.

Medical Economics and Insurance

Thomas G. Hamilton, Columbia City, Chairman; Thomas J. Conway, Terre Haute, Vice-Chairman; Chester A. Stayton, Jr., Indianapolis, Secretary; Charles M. Sinn, Evansville; Paul W. Holtzman, Bloomington; Edward J. Ploetner, Jasper; William A. Johnson, North Vernon; David R. Cain, New Castle; James M. Leffel, Indianapolis; Charles E. Geckler, Muncie; Kenneth O. Neumann, Lafayette; A. S. Kobak, Valparaiso; Richard Wagner, Huntington; Jack W. Hannah, Elkhart; William J. Miller, Lafayette.

Medical Education and Licensure

James B. Johnson, Greencastle, Chairman; John L. Cullison, Muncie, Vice-Chairman; Forrest LaFollette, Hammond, Secretary, John Sterne, Evansville; Betty Dukes, Dugger; John M. Paris, New Albany; Richard A. Snapp, Columbus; Frank Coble, Richmond, George T. Lukemeyer, Indianapolis; William Ringer, Williamsport; Leo Radigan, Gary; Lowell J. Hillis, Logansport; Joel Salon, Fort Wayne; Jene R. Bennett, South Bend; Merritt O. Alcorn, Madison; Peter J. Pilecki, Michigan City; Glenn W. Irwin, Jr., Indianapolis.

Public Health

T. O. Middleton, Bloomington, Chairman; Henry G. Nester, Indianapolis, Secretary; Daniel Hare, Evansville; Roy L. Fultz, Salem; R. M. Seibel, Nashville; Cleon M. Schauwecker, Greencastle; Wilson L. Dalton, Shelbyville; Stanley W. Burwell, Muncie; Theodore C. Person, Veedersburg; Gilbert Z. Given, East Chicago; Paul Sparks, Winchester; Theodore J. Smith, Whiting; Bertram Roth, Indianapolis; Charles H. Rushmore, Indianapolis, consultant.

Public Information

Frederic L. Schoen, Fort Wayne, Chairman; William B. Challman, Evansville, Vice-Chairman; William G. Moore, La Porte, Secretary; Louis Blessinger, Corydon; Herman J. Echsner, Columbus; William G. Bannon, Terre Haute; Robert D. Spindler, Shelbyville; Robert W. Harger, Indianapolis; Don W. Boyer, Lebanon; Thomas C. Chael, Munster; Fred C. Poehler, La Fontaine; Louis F. Sandock, South Bend; Loren H. Martin, Indianapolis.

Special Activities

Marvin E. Priddy, Fort Wayne, Chairman; Robert M. Brown, Marion, Vice-Chairman; Norbert M. Welch, Vincennes; Robert O. Zink, Madison; John E. Freed, Jr., Terre Haute; Harold C. Ochsner, Indianapolis; Henry Bibler, Muncie; Clarence G. Kern, Lebanon; Adolph Walker, East Chicago; K. G. Hill, New Castle.

Voluntary Health Agencies

Norman R. Booher, Indianapolis, Chairman; James H. Gosman, Indianapolis, Vice-Chairman; M. O. Scamahorn, Pittsboro, Secretary; Albert Ritz, Evansville; Ed R. Cantwell, Vincennes; T. A. Neathamer, Scottsburg; Harry R. Baxter, Seymour; William G. Bannon, Terre Haute; Wayne Endicott, Greenfield; William A. Karsell, Indianapolis; James S. Fitzpatrick, Portland; Albert E. Applegate, Frankfort; John G. Kolettis, Gary; Lloyd L. Hill, Peru; Richard Willard, Bluffton; Frank McGue, Michigan City.

Future Planning Committee

Earl W. Mericle, Indianapolis, chairman; Maurice E. Glock Fort Wayne; James S. Fitzpatrick, Portland; A. Wayne Ratcliffe, Evansville; Fred S. Carter, LaPorte; William B. Challman, Mount Vernon; James E. Wenger, Nappanee; Charles F. Gillespie, Indianapolis; Leslie M. Baker, Aurora, (Ex-Officio Members)—Patrick J. V. Corcoran, Evansville; G. O. Larson, La Porte; Lowell H. Steen, Whiting; Ralph V. Everly, Indianapolis; Frank B. Ramsey, Indianapolis.

1967-68 DISTRICT MEDICAL SOCIETY OFFICERS

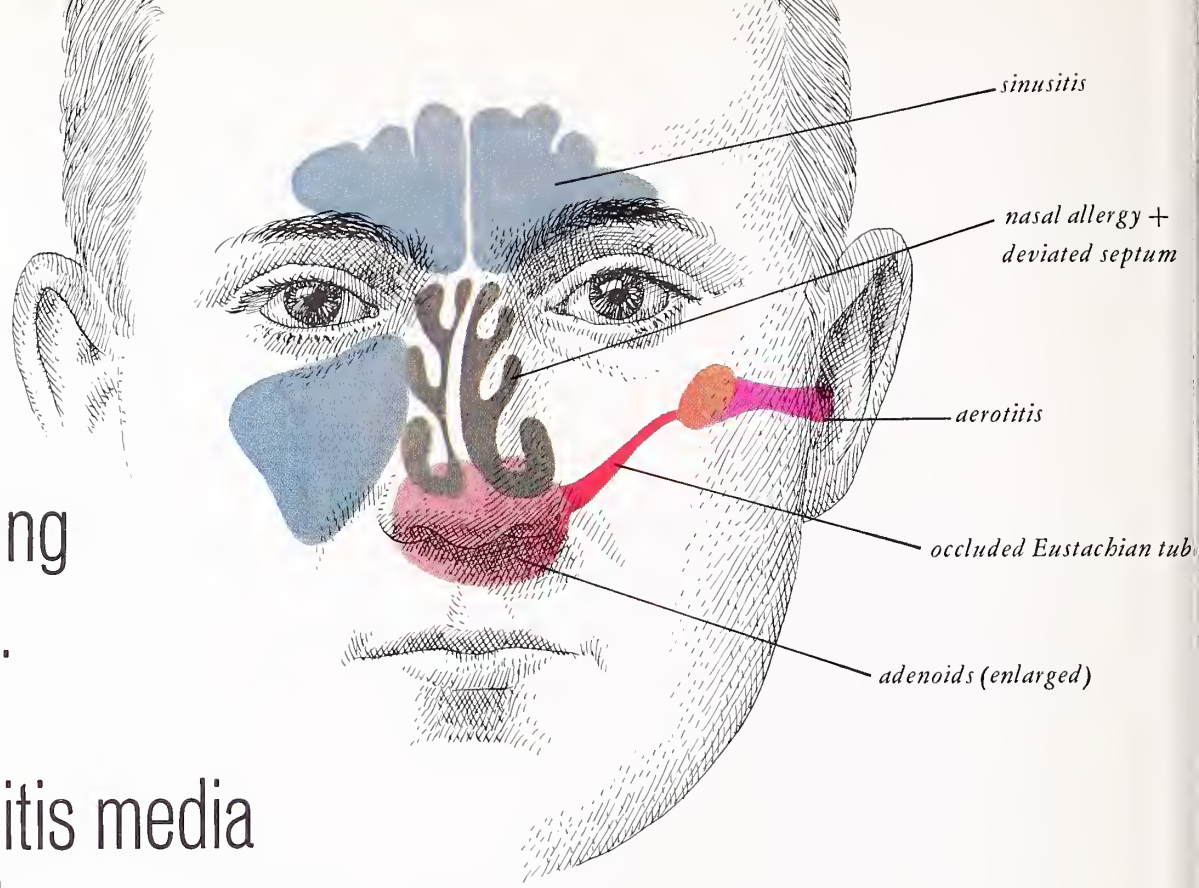
District	President	Secretary	Place and date of meeting
1.	R. E. Weitzel, Princeton	Fred Smith, Tell City	
2.	Brad Bomba, Bloomington	J. S. Brown, Carlisle	
3.	Daniel H. Cannon, New Albany	Elmer L. Wallace, New Albany	April 2, 1969, New Albany
4.	Bill E. Freeland, Batesville	William J. Warn, Milan	
5.	Jack Somerville, Clinton	Milton Herzberg, Clinton	
6.	Stephen Smith, Knightstown	David Wynegar, Richmond	
7.	John O. Butler, Indianapolis	Donald E. Stephens, Indianapolis	
8.	F. E. Stout, Muncie	Richard N. Philbert, Muncie	June 4, 1969, Muncie
9.	Martin Dickerson, Monticello	M. Ali Jehanyar, Monticello	May 22, 1969, Lafayette
10.	John J. Reed, Hobart	Raymond Doherty, Crown Point	
11.	Charles Wise, Camden	Fred Poehler, La Fontaine	September 18, 1968, Delphi
12.	Kenneth F. Isenogle, Fort Wayne	John J. Hartman, Angola	May 21, 1969, Fort Wayne
13.	E. C. Mueller, LaPorte	John Hildebrand, South Bend	September 18, 1968

vol. 3, no. 2

DORSEY Season

A journal within a journal published periodically in the interests of better medicine by Dorsey Laboratories, a division of The Wander Company, Lincoln, Nebraska 68501. Address communications to Keith W. Sehnert, M.D., Medical Director.

this issue:
serous otitis media
an original article
by Robert H. Lofgren, M.D.



the complaining earache... key to serous otitis media

Robert H. Lofgren, M.D.
Associate Surgeon, Massachusetts Eye and Ear Infirmary, Boston, Massachusetts

Serous otitis media is probably the most common ear problem in children, especially in the wintertime. Diagnosis is usually easy in adults, but may be quite difficult in children, especially the very young child where one has to depend almost entirely on the physical findings.

The symptoms of serous otitis are a fullness in the ear, a mild hearing loss and mild earache. The earache can best be described as a "complaining earache" instead of a "screaming earache" as found in purulent otitis media. A young child may be irritable and pull at the ear. In milder cases, and as the ear recovers, gurgling and popping noises can be heard in the ear.

On examination one may see a yellow tympanic membrane and if a fluid level is present the diagnosis becomes easy. However, the eardrum may be dull gray, or slightly pink, or even perfectly normal. Pneumomassage using a Siegle otoscope or a closed-head electric otoscope must be done on both ears, otherwise the diagnosis will be frequently missed. Attempted movement of the drum with the pneumatic otoscope produces either a sluggish motion of the drum or no motion at all instead of the easily movable normal drum. The Rinne test is negative and there is a 15-20 decibel conductive hearing loss. The bone conduction may be better than normal and an air-bone gap may exist even with the air conduction within normal limits. Occasionally one finds a false nerve deafness on the audiogram when thick glue-like fluid causes immobility of both the oval and round window. Both conditions return to normal when the fluid is removed, but they make the interpretation of screening audiograms very difficult.

There is no single cause for serous otitis. One factor always present is blockage of the eustachian tube, but this alone is not enough to produce fluid. There must also be an inflammatory reaction. Blockage of the eustachian tube may be caused by many conditions. In children the most common cause is enlarged adenoids. In the summer the next most common cause is allergy. Upper respiratory infections or influenza are common causes in the winter. Nasal allergy, acute and chronic sinusitis, nasal septal deformity and cleft palate can all cause eustachian tube obstruction. Some children may have a congenitally small eustachian tube, but fortunately they usually "grow out of the problem."

The first sign of a nasopharyngeal tumor is often a serous otitis. One must always rule this out in any adult who later in life develops repeated or persisting serous otitis. Causes sometimes overlooked are nasogastric tubes after surgery, simple obesity and cardiorenal disease, which may produce congestion in the mucosal lining of the eustachian tube. In recent years we have been seeing a new cause—acute otitis media, where the patient is adequately treated with antibiotics but where drainage has not been

established either through the eardrum or down the eustachian tube. A sterile exudate is left in the middle ear.

The inflammatory response may be caused by a marked negative pressure as in air otitis from flying, or it may be from a mild bacterial or viral infection in the middle ear. Serous fluid is a good culture medium and will frequently go on to purulent otitis media, especially if the original blockage was caused by an infectious process such as acute rhinitis or adenoiditis. When the infection heals there may be scarring in the middle ear mucosa. Mucous glands develop in this tissue and pour out a thick mucoid material. This ear usually looks normal until a pneumatic otoscope is used. The objectives in treating serous otitis are to remove the obstructing agent and to provide drainage from the middle ear. Often this can be accomplished by decongestants and nose drops. If large obstructing adenoids are present they should be removed. Sinusitis should be treated with oral decongestants or nose drops, plus antibiotics where indicated. Nasopharyngeal tumors should be treated. Allergies should be treated with antihistamines and, where indicated, by desensitization.

If the fluid does not clear with medical treatment within a week or two, a myringotomy should be done. If there is a question of active infection or if the fluid looks purulent, as is seen at the conclusion of acute otitis, cultures are taken. On adults this can be done in the office without anesthesia. It is no more painful than an intravenous needle for a blood test. A good safe topical anesthetic has a tremendous psychological value to the patient. Children under the age of 1 require no anesthesia. Between the ages of 1 and 3 anesthesia is not absolutely essential although a general anesthetic may be used to avoid the child's possible mistrust at follow-up examinations. I usually do the myringotomy at the same time as the adenoidectomy if the adenoids are enlarged. Once drainage has been established with decongestants or by myringotomy, positive pressure inflation of the middle ear is invaluable in forcing out the serous fluid and keeping it from reforming. The patient can do this himself by performing the Valsalva maneuver. This should be done several times a day, by taking a deep breath, holding the nose and blowing hard against the closed lips for a second or two.

In resistant cases where the fluid reforms as soon as the myringotomy heals, small polyethylene tubes are inserted through the myringotomy site. Insertion of the tubes, even in adults, usually requires an anesthetic. Good anesthesia can be obtained by infiltrating the canal wall with a local anesthetic, using a #27 needle. Once inserted the patient has no sensation of the tubes' presence. Be careful to caution the patient or parents not to allow any water to get into the ear canal while a myringotomy is open or a tube is in place. Water can be kept out by a pledget of lamb's wool in the ear canal or a cotton pledget thickly coated on the outside with petroleum jelly. I check these patients a week after a myringotomy to be sure it is healed and at two month intervals until the tubes have fallen out, usually within three to six months after insertion.

The mucoid type of fluid is so thick and tenacious that it is appropriately called a glue ear. It is aspirated only with difficulty through the eardrum, and occasionally must be removed through a tympanotomy. This thick, glue-like fluid is prone to recur, as the myringotomy usually heals long before the mucous membrane has returned to normal. Repeated myringotomies, as many as ten or twenty, were formerly required for this condition. Now polyethylene tubes are inserted initially when this thick, glue-like material is found. At times a subacute mastoiditis may accompany the serous otitis, which will necessitate a simple mastoidectomy before the condition can be eradicated. Usually the thin serous fluid readily responds to decongestants or to a myringotomy and removal of the eustachian tube obstruction. Occasionally, however, even serous fluid will repeatedly reform. For this, resection of the tympanic plexus of nerves which lies on the promontory of the middle ear has been carried out, as the tympanic branch of the glossopharyngeal nerve is the secretomotor nerve to the ear.

Failure to diagnose serous otitis is the most common cause of the recurrent, almost continuous otitis me-

Otoscopic Views

Normal

Acute Serous

Acute Purulent

Chronic Serous

dia seen in young children. In these cases a myringotomy will frequently provide a long-term cure without adenoidectomy or any other surgery. Failure to do this may allow the condition to go on to acute or subacute mastoiditis. Adhesive otitis media with scar tissue binding down the ossicles or tympanosclerosis may also result with permanent impairment of hearing. The prognosis for hearing with adhesive otitis or tympanosclerosis is usually poor. If the adhesions are removed, they reform, and the same is frequently true of tympanosclerosis even after a tympanoplasty. For many of these people a hearing aid is the only solution. The constant negative pressure in long standing serous otitis media may draw in either Schrapnell's membrane or the posterior superior portion of the eardrum forming a pocket to cause a chronic otitis media with cholesteatoma, which may not become apparent until twenty or thirty years later.

The non-medical complications of improper diagnosis or treatment may be even more serious. The irritable child, the frequent bouts of acute purulent otitis media with pain and fever, the expense of antibiotics and doctors, and the time lost from school or work affect the entire family.

In summary, serous otitis has many causes. There is a blocking of the eustachian tube and an inflammatory reaction in the middle ear mucosa, the latter usually caused by a mild infection. The treatment is to provide immediate drainage by decongestants and where necessary, by a myringotomy. The obstructing agent must be removed by surgery if it is adenoid or by oral decongestants, and antihistamines or nasal spray if it is an upper respiratory infection or allergy. Occasionally resistant cases require plastic tubes placed through the eardrum or other more radical surgery. Failure to treat properly leads to hearing loss which may be permanent, repeated acute otitis media or possibly even chronic otitis media with cholesteatoma.

References 1. Senturia, B. H. et al.; Middle Ear Effusions: Pathologic Changes of the Mucoperiosteum in the Experimental Animal, Ann. Otol. 71:632-648, 1962. 2. Grahne, B.; Serous Otitis Media, Acta Oto-Laryng. 58:1-8, 1964. 3. Sade, J.; Pathology and Pathogenesis of Serous Otitis Media, Arch. Otolaryng, 84:297-305, 1966. 4. Buckingham, R. A. and Ferrer, J. L.; Reversibility of Chronic Adhesive Otitis Media with Polyethylene Tubes, Laryngoscope 76:993-1014, 1966. 5. Chalat, N. I. and Lounsbury, E.; A Hearing Phenomenon and Serous Otitis, Laryngoscope 76:983-992, 1966. 6. Shucknecht, H. F.; Chronic Otitis Media in Children: A New Treatment, Clin. Pediat. 3:718-727, 1964. 7. Feuerstein, S. S.; Surgery in Serous Otitis Media, Laryngoscope 76:686-708, 1966. 8. Kapur, Y. P.; Serous Otitis Media in Children, Arch. Otolaryng. 79:38-48, 1964. 9. Silverstein, H., Miller, G. F., Jr. and Lindemman, R. C.; Eustachian Tube Dysfunction as a Cause for Chronic Secretory Otitis in Children, Laryngoscope 76:259-273, 1966.

You can relieve his congestion and sniffles and her concern with

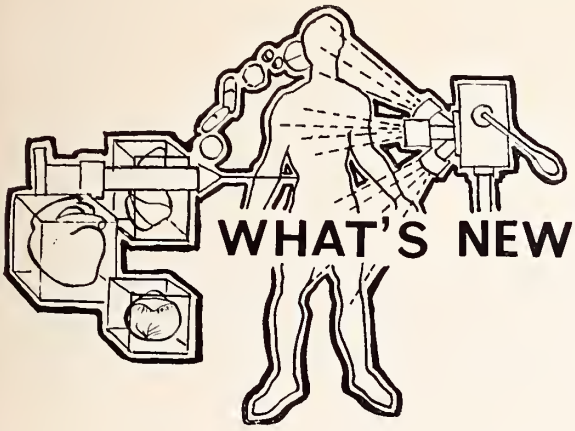
"The Orange Medicine"

You know it as Triaminic Syrup, but mothers of kids with colds and allergies know it as the orange-colored, good-tasting medicine that makes life a lot more livable at either end of the teaspoon. Triaminic Syrup contains not one, but two antihistamines, plus an effective oral nasal decongestant. This balanced formulation has promptly and effectively relieved nasal congestion for so many.

TRIAMINIC® SYRUP

Each teaspoonful (5 ml.) contains: phenylpropanolamine hydrochloride 12.5 mg.; pheniramine maleate 6.25 mg.; pyrilamine maleate 6.25 mg. Side effects: Drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The possibility of drowsiness should be considered by patients engaged in mechanical operations requiring alertness. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis. Dosage: Children 1-6, ½ tsp.; Children 6-12, 1 tsp.; Adults, 2 tsp. Administer every 4 hours. Supplied: Bottles of 4 fl. oz., pints.

(Advertisement)



Bio-Dynamics of Indianapolis announces the availability of three new blood chemistry kits. The new tests are total protein, globulin and alkaline phosphatase. The kits contain all the materials needed for the tests. A new meter face is now available and will be shipped free with new kit orders for use in the Universal Unimeter 250 which was introduced in June of last year.

* * *

Parke-Davis is adding a blood plasma substance called Albuspan to its product list. It is composed of normal human serum albumin and will be marketed in both a five percent solution and a 25% solution. Albuspan is recommended especially in the treatment of hypovolemic shock such as occurs in burns, trauma and crushing injuries in which loss of red corpuscles is not severe.

* * *

Travenol Laboratories are introducing the Triflex™ disposable examination gloves, made in non-sterile and sterile form. The gloves are made of vinyl and measure 10½ inches from fingertips to cuff. The non-sterile variety are packed in a plastic wall dispenser, 50 gloves to the box, in the same fashion as facial tissues are dispensed. The sterile gloves are in individual Peel-Pack envelopes.

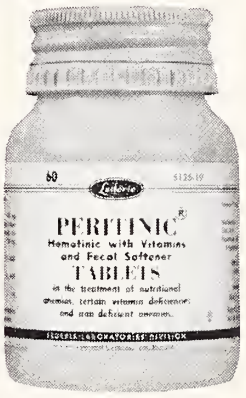
* * *

"Treating Cancer" is the title of a 20-page booklet, issued for the general public by the Public Health Service, which describes current methods of treating cancer by surgery, radiotherapy and chemotherapy. New operating room technics and recent advances in patient care and rehabilitation are also described. Single copies are available without charge from the Public Health Service, Washington, D. C. 20201. The booklet may be bought in quantity from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402, at 20 cents per copy.

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments, and surgical appliances and book publishers. Each item is published as news and does not necessarily constitute an indorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

anticostive* hematinic



PERITINIC®

Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

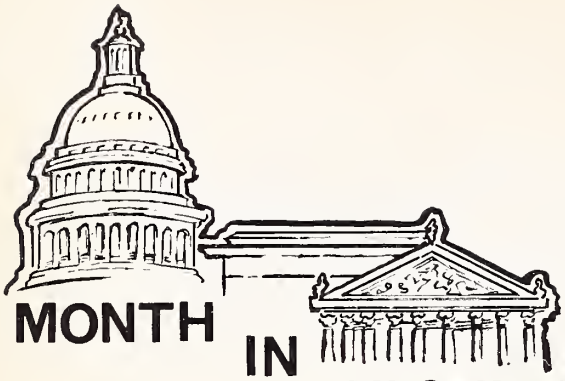
● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

* anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic? We'll send you samples if you'll send a request on your Rx blank, addressed to Department 150.)

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

488-7—6062



This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

WASHINGTON, D.C.—The American College of Radiology, defending the current use of x-rays by physicians, criticized published scare stories for causing unwarranted fears of x-ray examinations.

DR. RICHARD H. CHAMBERLAIN, a spokesman for the college, said articles such as one in a recent issue of The Ladies Home Journal distorted the facts in such a manner that it added up to "one of the most tragic things in medicine" by scaring people as to the possible effects of being x-rayed. Dr. Chamberlain said usage of x-rays by physicians in this country is "remarkably good."

"THE RISKS to patients in the performance for medical x-ray examinations are vanishingly small," he said. "Diagnostic x-ray examinations do not endanger the health of patients, despite a few shrill claims to the contrary. We could cite millions of instances where x-ray examinations provide lifesaving information to patients."

THE COLLEGE supported in testimony before the Senate Commerce Committee a radiation standards bill, proposed after reports of radiation leaks from color television sets.

"THE PUBLIC has the right to expect protection against harmful amounts of inadvertent exposure to radiation from the operation of electronic devices," Dr. Chamberlain said.

HE ADDED that much more is known today about the effects of radiation than about many other environmental contaminants. Although more needs to be learned about the effects of low levels of radiation, he said, "we do know with assurance that their potential for harm is very small."

"THE REAL tragedy occurs when even a single person may be misled by a distortion of radiation hazards to refuse a needed diagnostic x-ray examination," he said.

FDA PROPOSES NEW DRUG REGULATIONS

THE FOOD AND DRUG Administration (FDA) has proposed new regulations for the classification of drugs found both safe and effective for their labeled uses in a survey of more than 3,600 prescription drugs.

THE NEW PROCEDURES would open the way to increased competition within the drug industry by allowing firms to market drugs reclassified as "not new" or "no longer new" without submitting

and awaiting approval of new drug applications (NDA) by the FDA.

A MANUFACTURER that gets an NDA approval for a product has the right to market it exclusively. It is in effect an individual company license. Under the terms of the Food, Drug and Cosmetic Act, any medicine can remain in this "new drug" category regardless of how long it has been on the market.

THE NEW PROPOSAL would set up a system for reclassifying the pre-1962 "new drugs" recognized as effective in the drug efficiency study being conducted for FDA by the National Academy of Sciences-National Research Council. The review, authorized by Congress in 1962, covers 3,690 drugs—every drug marketed in this country between 1938 and 1962. The drugs under review had been approved as "new drugs" solely on the basis of safety.

FDA ANNOUNCED that two drugs—metyrapone and metyrapone ditartrate—would be the first "new drugs" reclassified under the proposal. Both were found effective for their recommended uses of testing the functioning of the pituitary glands. They are manufactured by CIBA Pharmaceutical Co.

IN ITS SECOND REPORT to carry out recommendations of the study of every drug manufactured in the United States between 1938 and 1962, the FDA notified the manufacturer of a drug used in the treatment of severely painful menstruation to provide evidence within 60 days that the product is effective for conditions listed in its labeling. The drug Lutrexin, manufactured by Hynson, Westcott & Dunning, Inc., of Baltimore, is available on prescription only.

THE FDA also has issued a new warning about dangers of the antibiotic drug chloramphenicol.

MEDICAID PROGRAM COST SPIRALS

HEALTH, EDUCATION and Welfare Secretary Wilbur Cohen estimated that the medicaid program may cost the federal government between $2.5 and $3 billion in the fiscal year 1971.

THE ESTIMATE for the next fiscal year (1968) is $2.1 billion. The original estimate for the current year was $1.7 billion but that proved substantially low and the administration has asked for $500 million more.

CONGRESS has put some restrictions on the medicaid program, effective this July 1, and they may result in holding down the 1971 costs below Cohen's estimate.

THE SOCIAL SECURITY Administration reported that the medicare Part B program, physicians' services, operated at a small deficit in fiscal 1967 which will be covered by the increases from $3 to $4 in monthly premiums.

THE PERCENTAGE of people 65 and over enrolled in the doctor bill insurance part of medicare went up from 92 to 95% during the six-month open enrollment period that ended April 1. About

Continued

Continued

700,000 older people who had missed out on their first chance to enroll signed up between October 1, 1967, and April 1 of this year. Now, 18.6 million of the 19.6 million persons 65 and over in the nation are now enrolled for medicare voluntary medical insurance.

SOCIAL SECURITY Commissioner Robert M. Ball said that the overall social security fund is in good fiscal condition. Medicare received $3.1 billion in fiscal 1967 and disbursed $2.6 billion, Ball said. He said estimates for the next 25 years showed that the program "has a favorable actuarial balance—namely, that total income over the 25 years ahead is expected to exceed total outgo."

COHEN told a House appropriations subcommittee that HEW was very much concerned and was making an intensive investigation of reported abuses by some physicians in federal medical programs.

HE SAID a number of allegations had been made but that he would not want to make an overall statement until the investigation was completed.

"A TYPICAL KIND of allegation concerns a doctor who goes into a nursing home—I will be just hypothetical about this—and he is there for an hour and then sends in a bill for an injection of something for every one of 50 people in the institution," Cohen said.

"THEN WE HAVE had cases of bills being submitted in which the evidence suggests that the volume of services that he is requesting to be paid for is beyond the ability of a particular person to handle. Well, he comes back to that allegation and says, 'I have a nurse and I have an assistant' and so on. So we have to look into each one of them on their merits. We are doing that now.

"THE POPULAR criticism usually has to do with the individual fee. I really don't think that is the major issue. The real issue is not so much the fee or the price per unit, but the number of units that the person is saying he delivered."

COHEN said he did not think such practices are widespread but that: "We have enough to be very much concerned about it."

INJUNCTION HALTS DIATHERMY DEVICE SALES

A PRELIMINARY injunction was issued to halt the sale of a diathermy device distributed by the Diapulse Corporation of America.

THE U.S. DISTRICT COURT for the Eastern District of New York enjoined sales of the Diapulse device, advertised for treatment of 49 diseases and conditions, including tuberculosis, typhoid fever, staph infections and gangrene.

THE DIAPULSE DEVICE was seized by FDA in 1965, and found to be misbranded on March 17, 1967, by a Federal court in Hartford, Conn.,

but the sale of the machine continued pending further appeals.

PHYSICIANS ENDORSE SAFETY CONTAINER BILL

A GROUP of physicians specializing in child health has endorsed a bill to require special safety containers for drugs, soaps and other household products involved in the poisoning of 500,000 children each year.

THE ACCIDENTAL POISONING Committee of the American Academy of Pediatrics endorsed the measure sponsored by Chairman Warren G. Magnuson, D-Wash., of the Senate Commerce Committee. The Academy, in a letter to Magnuson, said the bill was the only "practical way to eliminate hazards from drugs and household products."

THE GOVERNMENT announced a ban on interstate shipment of household products containing carbon tetrachloride—a substance used in some cleaning fluids.

THE FOOD AND DRUG Administration (FDA) said use of the chemical in a home constitutes a hazard to public health and added there are many safer substitutes available. According to the FDA, carbon tetrachloride can be fatal if the fumes are inhaled. The chemical can also cause damage to the liver, kidneys, brain and nervous system, the agency said. ◄

A hospital for the diagnosis and treatment of psychiatric illness

WABASH VALLEY HOSPITAL

(a not for profit corporation)

2900 North River Road (State Road 43 north)

West Lafayette, Indiana, Phone 317-743-3841

Active Psychiatric Staff	(Phone)
W. R. VanDenBosch, M.D.	447-6404
David L. Evans, M.D.	447-9155
Joe M. Martin, M.D.	743-1809
Edgar C. Stuntz, M.D.	
Limited private practice	
John H. Wilms, M.D.	
F. H. Spurlock, M.D.	92-2441
Alfred R. Heasty, M.D.	

Robert K. Jones, Ph.D.
Clinical Psychologist

Mrs. Margaret Keedy, A.C.S.W.
Psychiatric Social Worker

Elizabeth J. Snyder, R.N.
Director of Nursing Service

James Jones, B.P.E.
Director of Activity Therapy

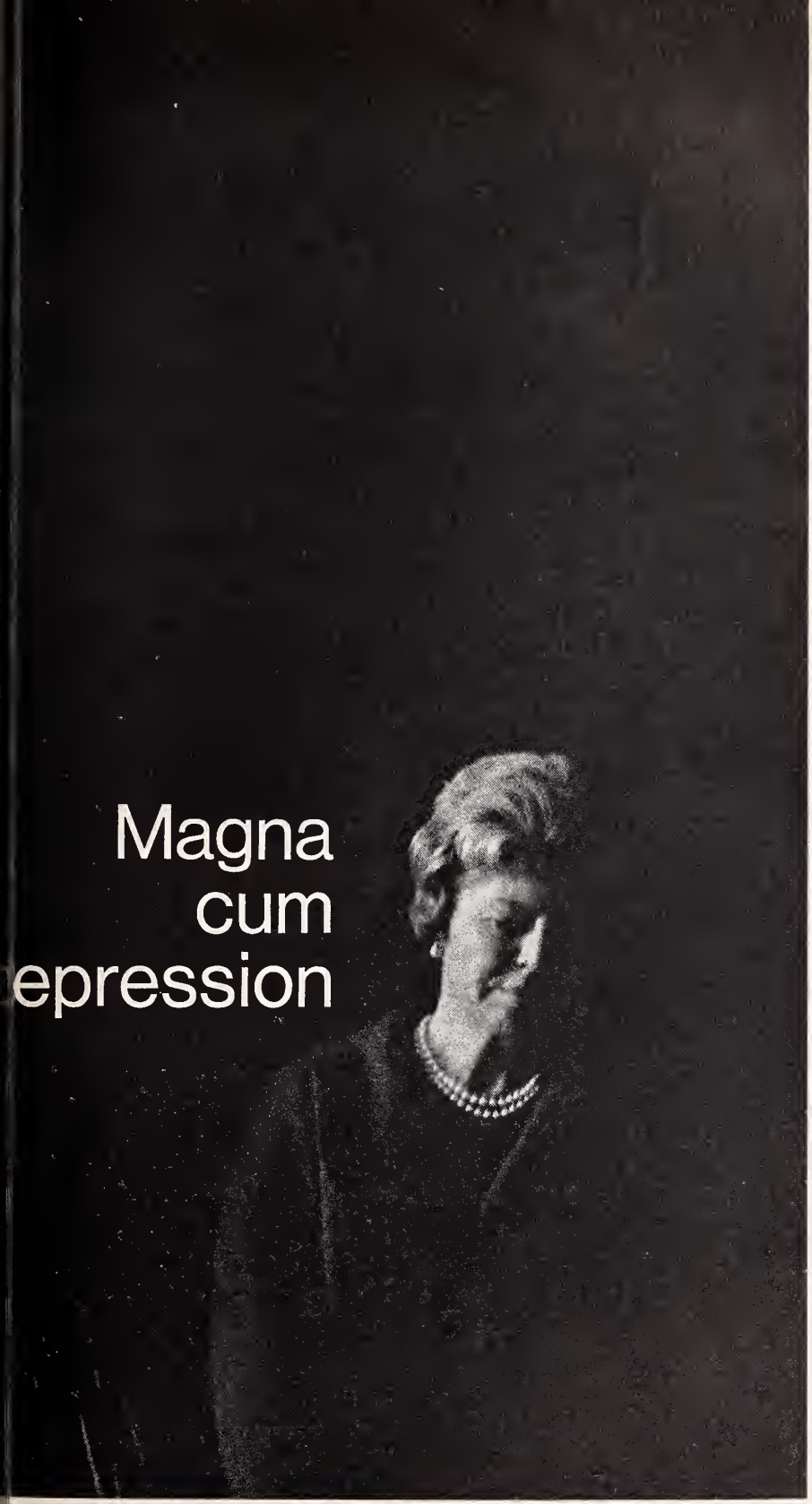
Donald R. Kinzer, Hospital Administrator

Admissions are arranged through referral to any active staff psychiatrist.

All general medical and surgical specialties in the community are available through physicians on the open consulting staff.

Tofrānil®, imipramine hydrochloride

Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy. Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy. Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when this compound was added to the regimen.
Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 ye of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, d turbances of accommodation, swea ing, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and dis orientation), activation of psychosis schizophrenics and agitation (inclu ing hypomanic and manic episodes which may require dosage reductio



Magna cum epression

For him, commencement.

For his mother, the beginning of his career may seem the end of hers. The end of feeling needed and useful. The beginning, perhaps, of a pathological depression.

Tofrānil can often relieve the symptoms of her depression. If it can relieve her mental anguish, you may be able to help her graduate into a new and fruitful life of her own.

Tofrānil could be her commencement, too.

Tofrānil® Geigy
imipramine hydrochloride

in depression

The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated.

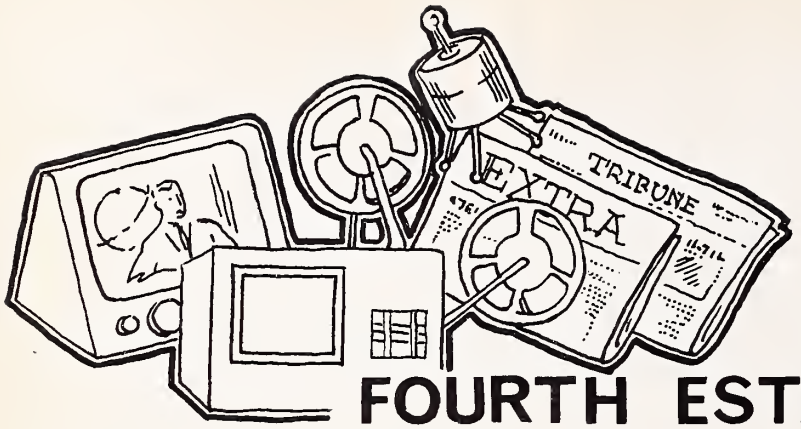
In patients with cardiovascular disease, hyperthyroidism or increased intraocular pressure; in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication or adrenergic neuron-blocking antihypertensive agents; and in those in the first trimester of pregnancy, the precautions discussed in the Prescribing Information should be carefully observed. Although toxic reactions severe enough to require discontinuation of Tofrānil are uncommon, please refer to the Prescribing Information for a description of such instances when discontinuation may be necessary.

/or addition of a tranquilizer or
porary discontinuation of the drug,
eptiform seizures, orthostatic
otension and substantial blood
sure fall in hypertensive patients,
ura, transient jaundice, bone mar-
depression including agranulocy-
s, sensitization and skin rash
uding photosensitization, eosino-
ia, and mild withdrawal symptoms
udden discontinuation after pro-
ed treatment with high doses.
asional hormonal effects (im-
nce, decreased libido, and estro-
ic effects) may be observed.
pine-like effects may be more
ounced (e.g. paralytic ileus) in
ceptible patients and in those
g anticholinergic agents (includ-
antiparkinsonism drugs).
patient Adult Dosage: Initially,
ng. daily, increased, if necessary,
50 or 200 mg. Maintenance dosage
/ be lower, 50 to 150 mg. daily, if
sible.

Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)R-46-850-C

For complete details, please refer to the full Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502



FOURTH ESTATE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

We Don't Need Another Doctor?

Is it possible this area doesn't need another doctor?

The Bi-County Chamber of Commerce and the Attica Chamber of Commerce feel the area DOES need another doctor and have made strong efforts to get one, as has the Williamsport Community Hospital Board.

Obviously these three groups concur, and a lot of other groups and individuals have the same concern.

According to reports, there is a critical shortage of doctors in many other communities in Indiana and attempts are constantly being made by the citizens in these communities to meet the need. It was reported the other day that Illinois faces the same problem, and needs 10,000 additional doctors.

But apparently the Indiana Medical Board doesn't share the same concern, or see the need, or perhaps just doesn't care whether the smaller and less populous areas have adequate medical personnel.

Four months ago, Dr. Atilano Salvo traveled almost half-way 'round the world in hopes of setting up a practice in Attica. He applied for a license to practice medicine in Indiana after looking over the situation, and in an interview said he found the people of the community "gracious and friendly."

Apparently he met all medical requirements, and the Indiana Medical Board was confident he is qualified to practice medicine in Attica or anyplace else in Indiana.

His license to practice has not been forthcoming, and Dr. Salvo is forced to sit and wait—for what, no one seems to know. Obviously the need is here—or a lot of people are badly mistaken. He is qualified, but he still has not been granted a license.

He has even asked for a temporary license, but this is apparently against the policy of the too powerful medical board.

So Dr. Salvo waits, not knowing what the decision is going to be—and back in the Philippines, his family also waits.

But Dr. Salvo can't wait forever. In fact, he said Tuesday he plans to wait only another month, and then if a decision is not made he must go back to his practice and his family in the Philippines.

If Dr. Salvo choses to return to the Philippines, who can blame him?

Four months is a long time to wait for a board to make a decision that affects his future, his family and his career.

Why is all the waiting necessary? The man is qualified—there is a crying need.

Doesn't Indiana want this man in their medical ranks? How many months, or years, might go by before another doctor comes along who is willing to settle in a small community?—*Attica Ledger-Tribune*, May 15, 1968.

Suicide Prevention

George S. Bond II, the new president of the Marion County Association for Mental Health, has announced the association plans to establish a center to provide help for potential suicides.

Dr. George E. Murphy, a pioneer in suicide prevention and psychiatry professor at Washington University, told the association's 19th annual meeting that "the tendencies (toward suicide) are very recognizable. Two-thirds of the people who commit suicide talk about their intentions, and this is the basis for the prevention efforts being made today."

According to Dr. Murphy, one of the founders of Suicide Prevention Inc. in St. Louis, chronic alcoholism and depressive conditions lead to two-thirds of all suicides and both are treatable. The purpose of a suicide-prevention center is to arrange the necessary treatment for a potential suicide.

The proposed Indianapolis suicide-prevention center will offer life-saving service. Its goal is praiseworthy and deserves the active support of the community.—*The Indianapolis News*, May 6, 1968.

Job For The Doctors

The government's program of free medicine for the needy — known as medicaid — is costing taxpayers hundreds of millions of dollars more than expected. It has led

Continued

Now . . . a new
alternate salicylate product
from Warren-Teed

Magan®
(magnesium salicylate, W-T)

magan®

an alternate salicylate

particularly offered for the management
of those chronic arthritic and rheumatic
patients with gastrointestinal intolerance
to aspirin and other salicylates

pain relief comparable to aspirin

Magan may provide effective salicylate therapy for a substantial number of your patients who cannot tolerate other salicylates because of gastrointestinal irritation.

Magnesium salicylate is recognized as a safe and effective alternate to aspirin. A controlled clinical study showed Magan to be not significantly different from aspirin as an analgesic in the treatment of arthritic patients.[1]

Reports from a private practice experience study indicate that Magan was tolerated by a high percentage of patients judged by their physicians to be unable to take aspirin or other salicylates due to gastrointestinal intolerance.[2]

1. Stern, S.B.: Med. Times, Oct. 1967
2. Reports on 1200 patients, data in files, Warren-Teed Pharmaceuticals, Inc. 1966

(See next page for prescribing information)

A different salicylate structure—
with no coating, no buffering
and it is sodium free

magan®
(Magnesium Salicylate, W-T)

microphotograph of magnesium salicylate crystals

Composition: Each orange-colored compressed tablet contains 5 grains (approximately 325 mg.) of magnesium salicylate, W-T (salicylic acid equivalent 75%).

Actions, Indications, Uses: The analgesic, anti-inflammatory, and antipyretic effects of MAGAN are similar to those of aspirin and other salicylates. Accordingly, MAGAN is indicated for the treatment of rheumatoid arthritis, osteoarthritis, nonarticular rheumatism such as bursitis, painful-shoulder syndrome, tendosynovitis, fibrositis, and other musculoskeletal disorders. The drug is also useful for the symptomatic relief of pain, aches, and discomfort of headache, neuralgia, minor injuries, dysmenorrhea, common cold and other minor infections of the respiratory tract. MAGAN (Magnesium Salicylate) may be tolerated by some persons intolerant to aspirin by reason of gastrointestinal irritation.

Contraindications: Because of the danger of hypermagnesemia, MAGAN is contraindicated in cases involving advanced chronic renal insufficiency. MAGAN, as other salicylates, may counteract the effect of uricosuric agents, and should not be prescribed for patients on such drugs.

Warning: As with all salicylates, high dosages of MAGAN should be avoided entirely or administered with caution to patients with liver damage, preexisting hypoprothrombinemia, vitamin K deficiency, and before surgery.

Adverse Reactions and Precautions: The same precautions applicable to salicylate therapy in general should be followed in prescribing MAGAN. Appropriate precautions should be taken in prescribing MAGAN for persons known to be sensitive to salicylates. If reaction develops, drug should be discontinued. Dosages of anticoagulants should be reduced with the administration of high dosage levels of MAGAN. *Impaired Renal Function:* Appropriate precautions should be taken in administering MAGAN to patients with any impairment of renal function including discontinuing other drugs containing magnesium and monitoring serum magnesium levels particularly if dosage levels of MAGAN are high. *Salicylate Poisoning:* Symptoms of salicylism, resulting from high doses of MAGAN, can be expected to resemble closely in character and intensity those associated with aspirin poisoning. These range from dizziness, drowsiness and ringing in the ears to vertigo, convulsions, coma and hypokalemia. Salicylate poisoning can be treated by intravenous fluids with sodium bicarbonate or lactate and potassium supplementation. In very severe cases, hemodialysis may be necessary. Vitamin K, 5-20 mg. orally or slowly i.v., usually restores the prothrombin time to normal.

Dosage: Adults 1 or 2 tablets every 4 hours as required with a full glass of water. In arthritis and other rheumatic conditions, higher doses may be used at the discretion of the physician. The experience with MAGAN in children is limited. The drug should not be used, therefore, for patients below 12 years until indications for use and dosage have been established.

How Supplied: Bottles of 250 and 1000 tablets.

WARREN-TEED PHARMACEUTICALS INCORPORATED
COLUMBUS, OHIO 43215
SUBSIDIARY OF **ROHM AND HAAS COMPANY**

to the expansion of welfare rolls to some nine million persons. States have had to dip into emergency funds to support their share of the program, and medicaid piled on top of medicare is blamed for overcrowded hospitals and doctor shortages, which have forced up prices for all medical care.

The foregoing are typical of press reports concerning the Federal Government's greatly expanded role in the health care picture. Against this backdrop of the seemingly insoluable problems of government health care, the president-elect of the American Medical Association, Dr. Dwight L. Wilbur, has summed up a list of profound changes in medicine and society that have taken place in recent years. He believes it is the responsibility of the medical profession to exert the leadership needed to help bring order out of the near-chaos that these changes have wrought.

Speaking for his colleagues and his profession, he declares, "We need to . . .exercise cooperative leadership with government, with industry, with labor and with all segments of the public. . . We must keep in mind the best ways to meet the needs. . . of the public for the benefits that medicine has to offer . . .We must demonstrate the effectiveness of the private system of medical care and the voluntary health insurance mechanism and we must make each of them more effective. . . We must expand medical school facilities and the number of students in them, as well as those in the allied health professions and services."

These are but a few of the points touched on by Dr. Wilbur, but they serve to indicate that the medical profession intends to help lead the way toward solutions of these problems instead of conceding their insolubility.

If, as indicated, members of the medical profession intend to provide the necessary leadership, it is a good omen for the future health and well-being of the nation. It looks like a big job for the doctors.—*Shelbyville News*, May 10, 1968.

Miscellany—

BY JILL

Last Friday was ground-breaking-day for the new wing to the hospital and it was a day marked for rejoicing not only by members of the hospital board such as Clifford Stevens, the local physicians, county commissioners, members of the county council, the hospital attorney, Kenneth Earnest, and the hospital administrator, Ed Kucinski, but all the nursing staff and general public.

The new wing of the hospital will increase the number of beds to 84 from the present 49 and thus will insure better care for patients who need hospital attention and will allow them to have this care in private or semi-private rooms.

At the present time each week finds patients on the first and second floor admitted on an emergency basis and placed in beds in the hall which have only temporary screens set up to give partial privacy.

(Since the advent of "the pill" no such overcrowding is found on the third floor. The "population explosion" in Rush County has become the "population arrest" with a marked decline in the number of births.)

For the past four and one-half years Miscellany has consistently written about the overcrowded conditions at the hospital. Many improvements suggested in the column have been carried out such as marking the county roads, blacktopping the alleys, planting trees, adding playground equipment in the parks, repaving the railroad crossings, etc., but in this one particular area, the case looked hopeless.

It was left for the third and present administrator, Mr. Kucinski, to cut through the red tape and finally get the plans approved, the money raised, the contractors and engineers signed with a go-ahead program to be completed in one year and nine months.

Miss Bosso and Mr. Sankowski were each, in turn, instructed by the board to have plans approved for building an addition to the hospital. The problems and program inherited from Miss Bosso and in turn from Mr. Sankowski were turned over to Mr. Kucinski, who was able to hurdle all problems and accomplish results. An endless number of conferences by the three administrators, have finally culminated successfully. The program is now underway. To Mr. Kucinski, to the hospital board, and to all who have worked so diligently on the project, congratulations!

The new wing will extend the hospital east to Perkins Street and there will be a new entrance. One of the additions will be a new enlarged dining room opening from the present kitchen. There will be long term care units, additional emergency rooms, increased out-patient examining rooms, laboratory facilities, x-ray equipment, and a room for physiotherapy.

The exterior of the new wing will be of brick. A "burnt buff" color has been discussed according to Mr. Kucinski. The decision will be made by the architect. Cost was the reason given for not using polished limestone to match the original hospital.

April is an ideal time, weather-wise, to start building and it is hoped that there will be no further delays in construction.—*Rushville Republican*, May 1, 1968. ◄

"Everything looks fine,
but we should do something about that extra weight you're putting on."

Get them while they're easily reversible.

Obesity doesn't happen suddenly. This insidious process has its beginning—and the chances of reversing it are better—during the *first 10 to 15 pounds of weight gain.* When a new dietary pattern must be established, consider the adjunctive use of BAMADEX SEQUELS. Combining the proven *anorexigenic* action of d-amphetamine with the *tranquilizing* effect of meprobamate, BAMADEX SEQUELS controls appetite throughout the day, usually with a single capsule daily.

Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.
Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Bamadex® Sequels®

Dextro-Amphetamine Sulfate (15 mg.) with Meprobamate (300 mg.)
Sustained Release Capsules

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York

381-S

Letters

to the editor

April 26, 1968

To the Editor:

During the past winter, large numbers of physicians, dentists, teachers, lawyers, and other professional persons received a reprint of an article on cigarette smoking which appeared in the January, 1968, issue of *True Magazine*. Among those receiving this reprint, undoubtedly, were readers of your journal.

Very serious questions have been raised as to the accuracy, impartiality, and integrity of this article and its method of distribution.

On March 21, *The Wall Street Journal* published an article by Ronald Kessler, revealing that the reprints were sent out not by *True*, which was the impression given, but by Tiderock Corp., a public relations firm employed by the Tobacco Institute.

I have entered *The Wall Street Journal's* article into the Congressional Record, along with comments by the Public Health Service and the American Cancer Society (March 27, 1968, p. S3415 et seq). The National Interagency Council on Smoking and Health has had this reprinted and informs me that copies will be furnished free upon request to the Council, at Box 3654, Central Station, Arlington, Virginia 22203.

Sincerely yours,

WARREN G. MAGNUSON
Chairman, Committee on Commerce
United States Senate
Washington, D.C. 20510

Correspondence

March 22, 1968

Dear Doctor Link:

I read your paper "Personal Observations of Medicine and Surgery in Indiana" in the February *Journal* and enjoyed it very much. It did me good to see my old teacher's name in print.

I entered medical school in 1905 and graduated in June, 1909. I took the competitive exam for City Hospital and got a place but was persuaded by my best friend to go to St. Anthony's Hospital in Terre Haute. I had very good training there but always thought I should have gone to City Hospital. However, I met my wife in Terre Haute and that was the best thing that ever happened to me. We lived happily together for 45 years before she passed away in 1955.

You were an assistant in Bobb's Free Dispensary at that time, about three or four years before I knew you. I remember well Dr. Ed Clark, on abdominal surgery; T. B. and J. R. Eastman and Tom Noble; E. W. Hodgen, (classmate of Oliver Wendell Holmes); Dr. Allen with his braces; Dr. Frank B. Wynn and many more. I held them all in high esteem.

I saw Dr. Oliver operate one time in my freshman year. I got a hospital ticket from an upper classmate. I also remember Dr. Wishard well and many others. . .Dr. Cook who did appendectomy through a one inch incision. . . Dr. Pfaff who was operating at St. Vincent's Hospital. A natural born artist, Dr. Kyte, of my class drew Dr. Pfaff's picture. The picture was a remarkable likeness and it pleased Dr. Pfaff.

INDIANA MEDICAL BUREAU
816 Hume Mansur Bldg.
634-5804

A Licensed Employment Agency
Specializing in Medical Personnel

Our 17th Year Of Service

Dr. John Morris, my anatomy teacher, got hard boiled occasionally but I liked him. And last, the wonderful old man, Dr. Brayton. I had the honor of riding in his buggy once. I was doing my three weeks stretch on out-service from Bobbs Free Dispensary. I had an O.B. case out in west Indianapolis and the lady asked me to look at her husband before I left. He had been very ill for a few days and had a breaking out. It was smallpox.

I reported it as such and the next day vaccinated the rest of the family, all except the newborn babe. Dr. Brayton came out in the afternoon to see my case. He promptly sent him to the Pest House. He had me vaccinate the babe at once. The babe had two or three convulsions from high fever when the vaccination took, but lived. Dr. Brayton asked me how I was so sure it was smallpox. I said, "I happened to be on your section when a hobo walked into the clinic with pustular smallpox and you borrowed a pin out of the lapel of my coat to prick one or two of the pustules." He laughed.

On our way out to see the patient we saw a bird and we stopped and watched it for awhile and apparently forgot all about the fact we were going to see a smallpox case. He gave me a nice talk on that species of bird — all about it. I had seen that species of bird all my life on the farm but it was just another bird to me. He was quite a naturalist.

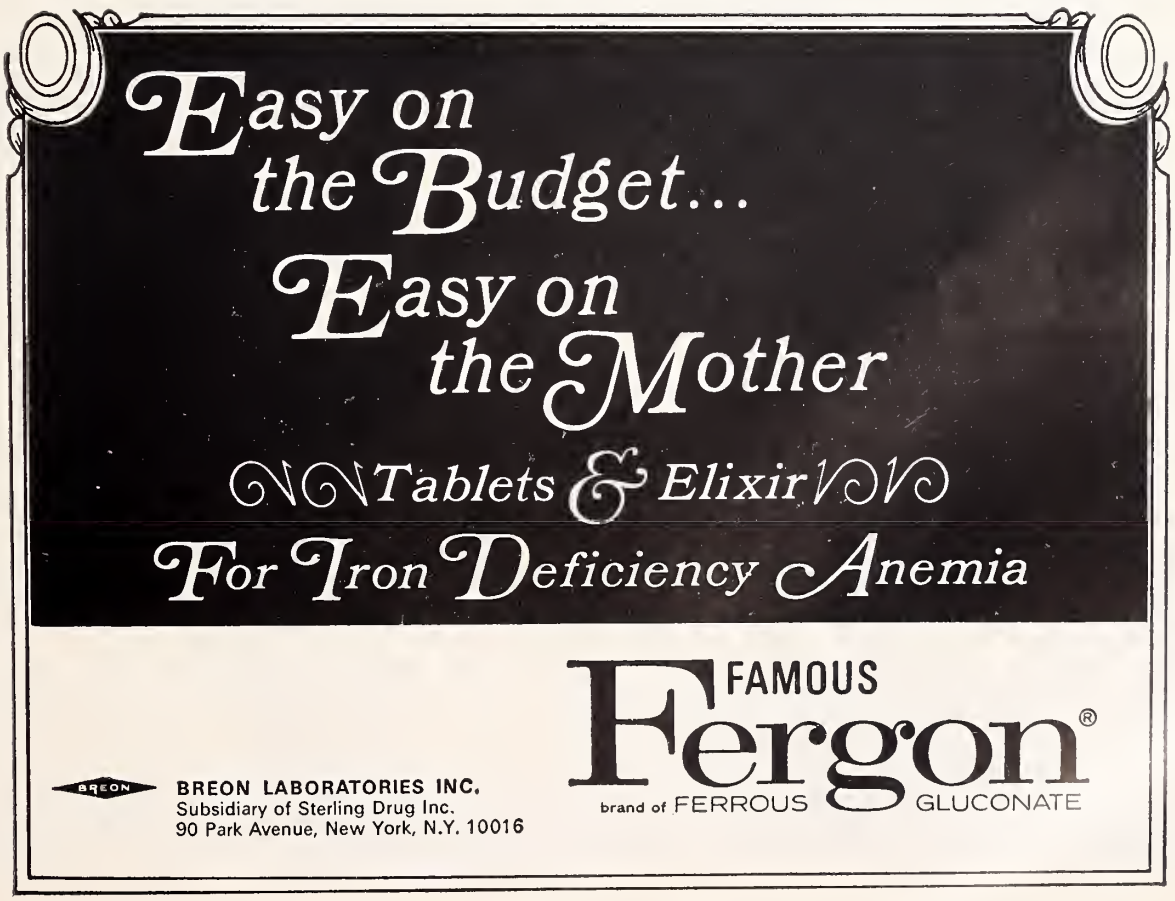
I also had the pleasure of listening to a lecture in Chicago at an A.M.A. meeting by one of the Mayo brothers. I think it was Will Mayo. He told how he and his brother would thread several needles for their father who was doing an operation and would stick them in the lapels of their coats so as to have them ready when their Dad needed them. Their father operated out in the home.

I retired in 1960 after 51 years, counting the year spent as an intern. We took two or three to seven weeks vacations each summer except in 1932. I have a son who has been curator of fish at the Chicago Museum of Natural History in Chicago for the past 30 years. I also have a daughter in California and one in Evansville at whose home I live. I will soon be 85 years old and am in good health.

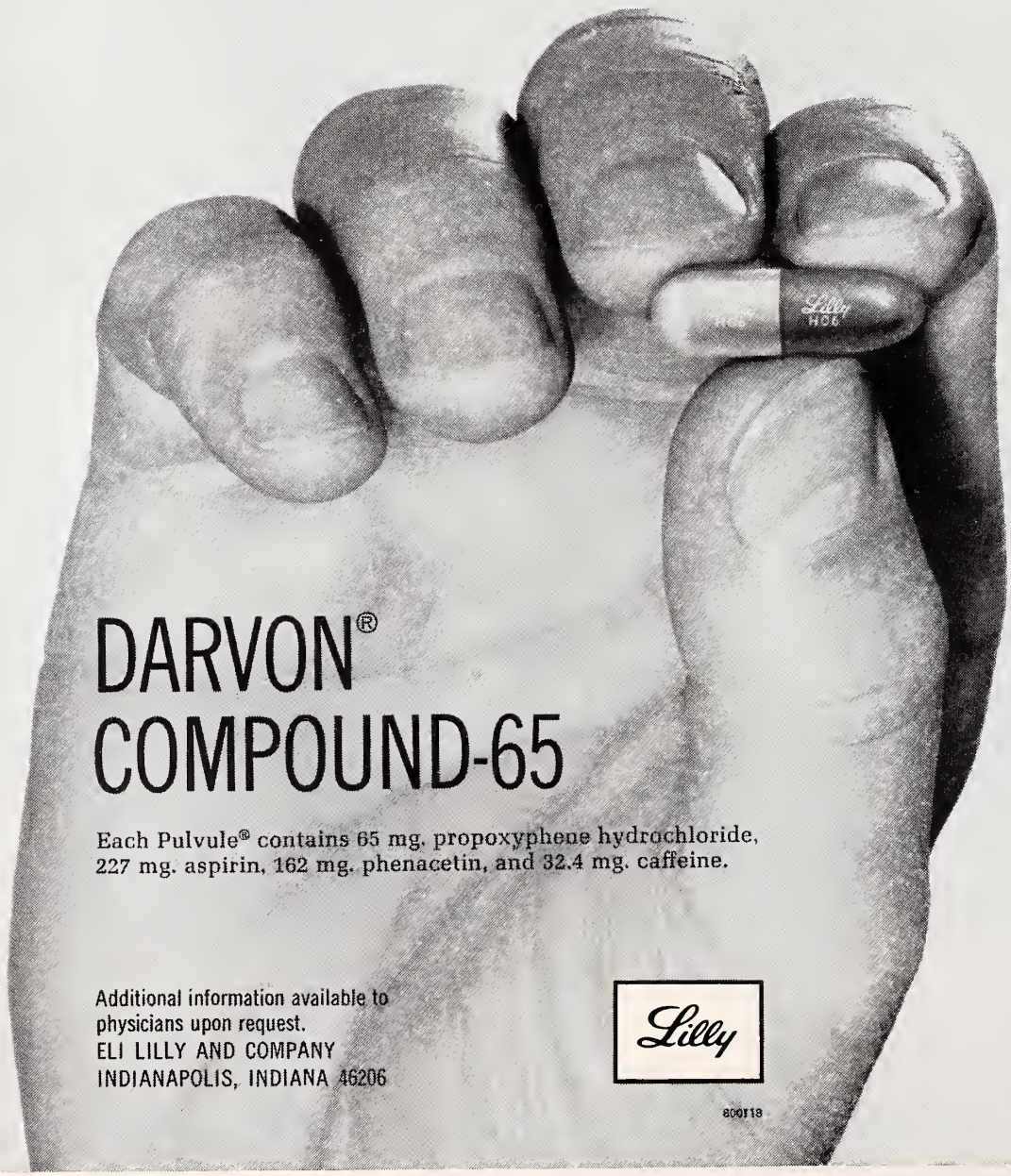
Dr. Carl Habich, Lillian B. Mueller, Herman Morgan (Indianapolis City Board of Health) and John Kingsbury, who lives out in east Indianapolis, were my classmates.

Lastly, I would like to say how much I have admired your surgery on thyroids all these years. ◄

Fraternally yours,
ARBA LEONARD WOODS
544 S. Hebron Dr.
Evansville, Indiana 47715



Part of the fine art of medicine



DARVON® COMPOUND-65

Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.

Additional information available to physicians upon request.
ELI LILLY AND COMPANY
INDIANAPOLIS, INDIANA 46206

Lilly

800118

The Journal of the INDIANA STATE MEDICAL ASSOCIATION
Supervised by THE COUNCIL
Volume 61 — July 1968 — Number 7

All that is pale and boggy is not allergic. Other causes for a pale, boggy nasal mucosa are described and discussed.

Significance of the Pale, Boggy Nasal Mucosa

IRVIN CAPLIN, M.D.
JOHN T. HAYNES, M.D.
DUANE HOUSER, M.D.
Indianapolis*

THE pale, boggy nasal mucosa has long been considered diagnostic of the allergic individual. Yet allergy is only one of many disorders responsible for this appearance. Allergists see many patients who have been told they have allergic noses in whom no allergy can be found. Bronchoscopists also frequently refer patients for allergic evaluation because bronchoscopy reveals the bronchial mucosa "to be allergic", and we often find no evidence of allergy.

There are several possible causes, other than allergy, for a pale and boggy nasal mucosa. We shall describe other causes including one which we have not seen previously described in the literature.

Criep[1] described part of the atopic pathology as due to reversible inflammatory swelling. There is edema of mucous membranes with eosinophilia of the blood, tissues and nasal secretions. Strem[2] states that the gross pathology in nasal allergy depends mainly on edema of the nasal mucous membranes. He also states that in the chronic stages, the mucosa tends to be hyperplastic and appear boggy and gray.

Recently a study at this institution arose following a serendipitous observation. A patient with pneumonia developed a profuse nasal discharge 24 hours after a tracheostomy was done. She was found to be stuffing toilet tissue into her nose to absorb the drainage. The nasal mucosa was pale, swollen, boggy, and had the typical bluish tinge so frequently characterized as due to allergy. The patient was not an allergic individual. Is it possible that either nasal plugging without infection or lack of aeration, regardless of cause, may also produce the pale, boggy nasal mucosa?

Permission was granted by the local laryngectomy society for examination of 16 of its members. All patients had had a laryngectomy from four months to nine years prior to our examination. The appearance of the nasal mucosa was recorded and a nasal smear for eosinophils was done on each patient.

The following data were obtained from 16 patients:

1. Five complained of stuffy noses. In two this was present before operation as well as afterwards. In three, the nasal stuffiness started four to six weeks after laryngectomy and had remained in two patients for two and one-half years and five years respectively.

2. Six patients described bouts of sneezing. In only one was the sneezing worse after surgery.

3. Only one patient used medication for his nasal stuffiness.

4. One patient had asthma associated with his nasal stuffiness. His nasal smear revealed no eosinophils. Another patient had hives. No other personal history of allergic diseases was obtained.

5. Three patients had a positive family history of allergic disease.

6. Nasal smears for eosinophils revealed none in 11 patients, five percent in one and eight percent in another.

7. The appearace of the nasal mucosa was compiled as follows:

No. of Patients:

Pallor	Boggy	Boggy and Blue
16	6	2
Normal Moisture		Dry
5		3

* From the Department of Allergy, Methodist Hospital Graduate Medical Center, Indianapolis 46202.

Discussion

Patients with nasal polyps who also have a boggy, pale nasal mucosa are frequently seen. In some of these patients we find evidence of allergy. In many we do not. Duchaine[3] states that polyps are due to the same changes occurring in the nasal mucosa as occur in the sinuses in hyperplastic chronic sinusitis. He states that these changes are irreversible, due to bacterial allergy and are unresponsive to treatment directed exclusively against extrinsic allergens. Bacterial allergy in relation to such a condition is difficult to prove or disprove. Sheldon[4] feels that nasal polyps may appear not only in allergic rhinitis, but may result from any chronic irritation. He stresses the frequency of the triad of nasal polyps, aspirin sensitivity, and persistent wheezing. A pale and boggy nasal mucosa is nearly always present with nasal polyps, regardless of etiology, unless there is a superimposed secondary infection.

Vasomotor rhinitis is a term which has been variously defined and interpreted. It has been described as emotional, due to physical factors, irritants, nerve reflexes, and perhaps as an allergic rhinitis which has defied detection.[3-5] Our understanding of vasomotor rhinitis is chronic nasal obstruction which is frequently caused by emotional tension, aggravated by irritants such as smoke and frying foods, as well as physical factors. The usual cause and effect relationship due to allergens such as inhalants and foods is not found; yet examination usually reveals the pale, boggy nasal mucosa so frequently ascribed to allergy.

Myxedema frequently causes nasal plugging and nasal discharge, and a pale mucosa. Thyroid extract relieves the nasal symptoms.

Occasionally one sees a rhinitis associated with pregnancy. The nasal mucosa is pale and boggy. The symptoms disappear following delivery.

Cronic nasal obstruction with a pale nasal mucosa is frequently seen following nose drop habituation. Sheldon[4] terms this "rhinitis medicamentosa." These patients develop a rebound edema of the nasal mucosa when the effect of the vasoconstrictor has worn off. It becomes necessary to repeat the nose drops, often every two to four hours for relief of obstruction. If there is no other underlying cause, this condition will correct itself within two weeks if nose drops are discontinued.

The 16 patients described with a permanent tracheal fistula all had a pale nasal mucosa. In none was there nasal obstruction although one patient used a proprietary nasal inhaler on the average of twice weekly for nasal stuffiness. Most of the breathing in these patients is done through their fistulous tracts. Could it be that the lack of aeration somehow contributes to the pallor of the nasal mucosa? Eight of these patients also demonstrated bogginess. Does lack of aeration also lead to bogginess in some patients? We can only speculate. The present study cannot answer this. However, it would appear that objective evidence of pallor, and often bogginess of the nasal mucosa is seen in many conditions, in which there is a lack of aeration in the absence of infection. Does the lack of aeration produce edema or does edema produce lack of aeration or do both sequences occur? It would appear that in allergic disease the antigen-antibody reaction produces edema and is followed by a diminution of aeration.

Summary

There are many mechanisms which lead to a pale, boggy nasal mucosa. Reversible inflammatory edema of allergy, obstruction from nasal polyps, nervous tension in vasomotor rhinitis, hormonal imbalance in myxedema, pregnancy, and lack or diminution in aeration in the presence of a permanent tracheal fistula can all produce this entity.

The pale, boggy nasal mucosa is erroneously considered diagnostic of allergy by most physicians. In the face of this clinical observation, the physician should explore the possibility of the many likely causes. Many patients have spent months and often years exploring foods and inhalants as possible causes when an allergic diagnosis, which is not there, has been suggested. These patients should not be placed in the allergic wastebasket. There is nothing pathognomonic of allergy. In allergy there is always a cause and effect relationship. One sign or symptom does not necessarily make the diagnosis. A definitive diagnosis should be made.

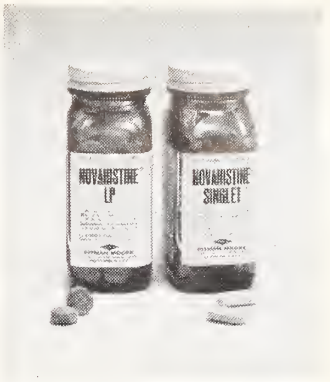
REFERENCES

1. Criep, Leo H.: *Clinical Immunology and Allergy*, Grune and Stratton, 1962.
2. Strem, Edward L.: *The Allergic Child*, edited by Frederic Speer, Harper and Row, 1963; Chapter 18, page 275.
3. Duchaine, J.: *International Textbook of Allergy*, edited by J. M. Jamar, Charles C Thomas Publishers, 1959, Chapter 7.
4. Sheldon, John M., Lovell, Robert G., Mathew, Kenneth P.: *A Manual of Clinical Allergy*, 2nd edition, W. B. Saunders Co., 1967.
5. An Experimental Approach to Psychomatic Phenomena in Rhinitis and Asthma, *J. Allergy* 21:1, 1950. ◄

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® tablets in two different formulations.

And let you control the dosage.



Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.
Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

With Novahistine LP tablets and Novahistine Singlet™ tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever. Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

DOW **PITMAN-MOORE** DIVISION OF THE DOW CHEMICAL COMPANY, INDIANAPOLIS

"Nothing else I've tried seems to work, so I decided to give you a crack at it."

The Mono Test (Wampole) and the Heterophile Antibody Test performed in parallel for 197 patients indicates a high enough correlation to warrant using the time-saving Mono Test as a screening procedure, with all positive results to be checked with the heterophile test.

Comparison of the Mono Test and the Heterophile Antibody Test

H. T. RUSSELL, M.D.
W. F. RICCHETTI, M.D.
EDITH CARLSTONE, M.T. (ASCP)
*Lafayette**

THE purpose of this communication is not to present any original material but is to compare the results of the Mono Test (Wampole) and the Heterophile Antibody Test which were performed in parallel in our laboratory on the sera of 197 patients over a nine-month period. Of this group, 56 had positive Mono tests and 141 had negative Mono tests.

The tabulated data (Table I) show the number of positive tests for each heterophile antibody titer and the results of absorption studies (differential test) on these patients having heterophile titers of 1:28 thru 1:224.

It is reasonable to assume that all patients with a heterophile antibody titer of 1:448 had infectious mononucleosis since the heterophile test would not be requested unless the patient had suggestive clinical findings and/or laboratory findings. Therefore, in these cases, the positive Mono test correlated with the heterophile test. In the seven patients with titers of 1:224, all showed titers following guinea pig absorption in dilutions "not more than three tubes below" the presumptive test level and all showed a decrease of at least two dilutions following beef erythrocyte absorption, so all can be considered as positive. In the four cases with titers of 1:112, three gave positive differential tests and one gave a negative differential test. In the 1:56 group, all gave a positive differential test. In the 1:28 group, both gave negative differential tests.

In the patients having a negative Mono test, (Table II) the highest heterophile titers obtained were 1:448 which occurred in three

PATIENTS WITH POSITIVE MONO TESTS

Heterophile Titer (Presumptive Test)	Number of Patients	Results of Differential Heterophile Test
1:7	1	
1:14	2	
1:28	2	Guinea pig Neg, Neg
		Beef eryth. 1:28, Neg
1:56	5	Guinea pig 1:14, 1:28, 1:14, Neg, 1:28 Beef eryth. 1:28, 1:56, Neg, 1:7, Neg
1:112	4	Guinea pig 1:56, 1:56, 1:7, 1:56 Beef eryth. 1:14, 1:28, Neg, Neg
1:224	7	Guinea pig 1:112, 1:224, 1:112, 1:112 Beef eryth. 1:56, 1:14, Neg, Neg Guinea pig 1:56, 1:112, 1:28 Beef eryth. Neg, 1:28, 1:14
1:448	5	
1:896	5	
1:1792	5	
1:3584	9	
1:7168	11	
TOTAL	56	

TABLE I

* From the Department of Pathology, St. Elizabeth Hospital, Lafayette 47904.

PATIENTS WITH NEGATIVE MONO TESTS

Heterophile Titer (Presumptive Test)	Number of Patients	Results of Differential Heterophile Test
No titer	37	
1:7	29	
1:14	43	
1:28	7	Guinea pig Neg, Neg, Neg, Neg, Neg Neg, Neg Beef eryth. Neg, 1:7, 1:7, 1:14, 1:14 Neg, Neg
1:56	11	Guinea pig Neg, Neg, 1:7, Neg, Neg Neg, 1:7 Beef eryth. 1:14, 1:14, Neg, 1:7, 1:56 1:56, 1:7 Guinea pig 1:14, Neg, Neg Beef eryth. 1:14, 1:14, Neg
1:112	9	Guinea pig 1:14, 1:14, Neg, 1:7, Neg 1:14 Beef eryth. 1:28, 1:28, 1:28, 1:14, 1:28 1:14 Guinea pig Neg, 1:28, 1:56 Beef eryth. 1:28, 1:7, Neg
1:224	2	Guinea pig 1:14, 1:28 Beef eryth. 1:28, 1:14
1:448	3	
TOTAL	141	

TABLE II

patients and we assumed that these were positive for infectious mononucleosis. Of the two patients with 1:224 titers in the presumptive test, one had a positive and one had a negative differential test. In the 1:112 titer group, one had a positive and one had a negative differential test. In the 1:56 group, one had a positive and all of the others were negative. The 1:28 titer group all had negative differential tests. Patients with titers of 1:14 or less in the presumptive test are considered negative and the Mono test correlated with the presumptive test in 109 such cases. Therefore, in the 56 cases giving positive Mono tests, the differential heterophile antibody test correlated in 51 cases or 85%. In the series of 151 cases having negative Mono tests, the differential test correlated in 96%.

Discussion

The procedure for the presumptive heterophile agglutination test requires washed sheep cells which must be washed three times for five minutes, centrifuged 10 minutes and suspended in a two percent saline suspension. The serum to be tested must be inactivated for 30 minutes at 56°C. Serial serum dilutions are made and cells added to each of the 12 tubes. The test is allowed to stand for two hours at room temperature and read for macroscopic agglutination. If the presumptive test is positive in a titer of 1:28 or higher, the serum should be absorbed with guinea pig kidney and beef erythrocyte antigens and the titer repeated. The absorption technic requires another two hour incubation period.

The Mono test is a rapid slide agglutination test. Either non-inactivated or inactivated serum can be used, although a rare false negative may occur with non-inactivated serum. The test serum, positive control, and negative control are each tested on a slide with specially treated cells. The results are read within two minutes.

When one considers the relative ease of performing the Mono test, and the very low percentage of false negative tests, it is apparent that the Mono test is a very valuable procedure when used as a screening test for infectious mononucleosis. Since the test may give as many as 15% false positive tests, all positives should be checked with the presumptive heterophile test. If the presumptive test is in the doubtful range, 1:28 up to 1:224, the differential test should be done. Since about four percent false negative results occur with the Mono test, the clinician should understand that this possibility exists and he should order repeat Mono tests or a heterophile test in patients who have a negative Mono test but who have highly suggestive clinical and/or laboratory findings. When used in this manner, the Mono test will be of great value to physician, patient and laboratory, since it will eliminate the need for performing the more time-consuming heterophile test in about 75% of patients suspected of having infectious mononucleosis. ◄

Clomiphene Citrate (Clomid) has been released recently by the FDA. Its use for the treatment of anovulation due to ovarian disorders is described. It is effective for the small number of infertility patients who are anovulatory and has few side-effects.

Ovulation Induction With Clomiphene Citrate

CHARLES R. ECHT, M.D.
JERRY A. GOODMAN, A.B.
*Indianapolis**

THE recent use of ovulation stimulatory medications has been a most exciting addition, not only to the gynecological but also the lay literature. Ten years ago women who were infertile due to anovulation (only about 10% of all female infertility) were unable to be aided to any significant degree unless the etiological factor was an extra-ovarian (adrenal or thyroid) disorder. However recent advances have been made to aid this category of patients.

The three major types of medications used to stimulate anovulatory patients due to ovarian disorders and occasional pituitary failure consist of one of the three following medications: follicle stimulating hormone (FSH), extracts of urine (from postmenopausal patients) which contain large amounts of human FSH called Pergonal, and clomiphene citrate (Clomid). Pergonal and human FSH are available only on an investigational basis. However, Clomid has recently been released by the FDA and therefore, the presentation of this data appears pertinent at this time. The prerequisite to the use of any one of these medications requires an intensive endocrine and gynecologic investigation. In addition, the mode of administration of FSH and Pergonal require daily intramuscular injections (7-14 days) and additional intramuscular injections of human chorionic gonadotrophin (HCG).

Clomid is an oral preparation which is a derivative of TACE (chlorotrianisene) an estrogen[1] and was first used as a contraceptive agent in rats.[2] However, when used in the human female it was found to have an opposite effect.[3] The mode of action is still in question. Although Clomid is an analogue of estrogen, it has been shown to have antiestrogenic properties.[2] Whether this competitive action of clomiphene citrate acts as the level of the ovary, pituitary or hypothalamus (or all three in combination) is still in question.

Thirty-seven women in the past 24 months have been treated. Thirty-two of these patients were nulligravid and three represented secondary infertility problems. The patients in this study were between the ages of 18 to 36 years.

The categories of symptoms of patients studied included oligomenorrhea (15) (infrequent menstruation[4]); secondary amenorrhea (15) (abnormal cessation of menstruation after the menarche[4]); primary amenorrhea (5) (failure in the normal establishment of regular menstrual cycles, so that the first period is delayed or does not occur[4]) and anovulatory cycles (2). Of the 15 patients with secondary amenorrhea, the diagnosis of polycystic ovarian disease was made in 13. In one of the 15, the diagnosis of premature menopause was made and one diagnosis was undetermined. Of the five patients with primary amenorrhea, two were diagnosed as hypogonadotrophic-hypopituitarism, one had ovarian hypoplasia and two were unexplained.

Preceding Clomid therapy, all patients underwent a complete history and physical examination. Endocrine laboratory studies performed on all patients included 17-ketosteroid and 17-hydroxysteroid determinations, endometrial biopsies and vaginal smears, skull films of sella turcica, and protein bound iodine determinations. Endogenous estrogen production was also evaluated by utilizing Delalutin (17-alpha-hydroxyprogesterone caproate) or Depo-Provera (6 alpha-methyl-17 alpha-acetoxy-progesterone) intramuscularly and awaiting menses. Basal body temperature charts were used to evaluate ovulation.

The dosage of 50 mg. of clomiphene citrate was given orally for five days beginning on day five (if known) of the menstrual cycle. If the patient responded by ovulation (diagnosed by endometrial biopsy and biphasic basal body temperature charts), the identical dosage was continued for the following cycle. If the patient did not respond, the dosage was increased to 100 mg. for five days for the following cycle.

* From the Department of Obstetrics and Gynecology, Indiana University Medical Center, Indianapolis 46202.

Three of the patients with oligomenorrhea also received 4000 I.U. of HCG intramuscularly. This was administered four-seven days after the last Clomid treatment.

Results

The resulting ovulations in our study are summarized in Table I. Clomiphene citrate was administered to 37 patients for 84 cycles. Ovulation was diagnosed in 49 (58.2%) of the cycles. In 17 (20.0%) cycles, ovulation was uncertain and in 18 (21.8%) cycles, no ovulation occurred. The latter group included one with ovarian hypoplasia, two with hypogonadotrophic-hypopituitarism, and one with premature menopause. In these latter patients, expectancy of ovulation was admittedly very poor. These patients constituted seven treatment cycles.

Condition	No. Patients	No. Treatment Cycles	No. Ovulations	Uncertainties	Anovulations
1. Oligomenorrhea	15	40	27	9	4
2. Secondary Amenorrhea					
a. Polycystic ovary	13	25	16	6	3
b. Etiology unknown	1	4	4	0	0
c. Premature menopause	1	2	0	0	2
3. Primary Amenorrhea					
a. Hypogonadotrophic-hypopituitarism	2	2	0	0	2
b. Ovarian hypoplasia	1	3	0	2	1
c. Etiology unknown	2	3	0	0	3
4. Anovulatory Cycles	2	5	2	0	3

TABLE I

PATIENT	CULDOSCOPY DIAGNOSIS ** Cuidoscoped *** Not Culdoscoped		CYCLES 1	2	3	4	5	6
R.S.	**	Normal	50 x 5 (+)	50 x 5 (–)	100 x 5 (+)	100 x 5 (–)	100 x 5 (+)	100 x 5* (?)
B.W.	**	Normal	100 x 5 (+)	100 x 5 (?)				
C.S.	***	Small ovaries	50 x 5 (–)	50 x 5 (+)				
E.V.	**	Normal	50 x 5 (+)	50 x 5 (+)	50 x 5 (+)			
B.T.	**	Normal	50 x 5 (+)	50 x 5 (+)	50 x 5 (+)			
A.K.	***		100 x 5 (?)	50 x 5 (?)	50 x 5 (–)			
S.H.	***		100 x 5 (?)					
A.H.	**	Normal	100 x 5 (+)	100 x 5 (+)	100 x 5 (?)	100 x 5 (?)		
M.M.	**	Right ovary cystic. Left ovary normal. Ovarian and uterine adhesions.	50 x 5 (+)					
A.O.	**	Normal ovaries with thin cortex.	50 x 5 (+)	50 x 5 (–)	100 x 5 (+)	100 x 5 (+)	100 x 5* (+)	100 x 5* (+)
E.S.	**	Normal	50 x 5 (+)	50 x 5 (+)	100 x 5 (+)			
J.K.	**	Normal	50 x 5 (+)					
D.R.	***		50 x 5 (–)	100 x 5 (–)				
D.D.	***		50 x 5 (+)	50 x 5 (+)	50 x 5 (+)			
H.S.	**	Normal ovaries. Mild adhesions on left.	50 x 5 (+)	50 x 5 (+)	50 x 5 (+)			

* HCG Administered Post-Clomiphene

Cycles: + = Ovulation
– = No Ovulation
? = Uncertain

TABLE II

Oligomenorrhea

The pretreatment menstrual pattern varied in these oligomenorrheic patients from one-six months. All patients demonstrated adequate endogenous estrogen production as verified by vaginal smears, endometrial biopsies and progesterone withdrawal bleeding. Of the 15 patients with oligomenorrhea, four revealed slightly elevated 17-ketosteroid levels (15.0 to 19.1 mg./24 hours) prior to treatment. Because of the elevation, these patients underwent adrenal suppression in an attempt to lower the steroid level and initiate ovulation. However, despite a decrease in the 17-ketosteroid level, ovulation did not occur. These four patients were then treated with Clomid and this resulted in eight ovulations of 11 treatment cycles.

Table II demonstrates the culdoscopic findings, the separate dosages and cyclic results for each patient with oligomenorrhea.

All of these oligomenorrheic patients with the exception of one are married and have been infertile from 15 months to 10 years. No relationship seems to exist between length of infertility and response to Clomid in this group. It is of interest to note that patient C.S. was found to have a unicornus uterus with one fallopian tube. Patient A.O., prior to treatment, showed endometrial hyperplasia which disappeared after her first Clomid cycle. Due to erratic temperature recordings during the second treatment cycle of E.S., the dose was increased to 100 mg. for five days in cycle three.

Secondary Amenorrhea

Of the 15 patients with secondary amenorrhea, 13 exhibited polycystic ovarian disease (one had associated pelvic inflammatory disease and a left hydrosalpinx). Two patients demonstrated elevated levels of 17-ketosteroids (19.0 mg. and 28.0 mg. /24 hours record). These levels dropped considerably (4.1 mg. and 10.0 mg.) with dexamethasone suppression. No ovulation resulted in

subsequent corticoid therapy. Eleven patients had proliferative endometriums as shown by biopsy preceding treatment. One patient possessed an inactive endometrium. Although culdoscopy verified polycystic ovaries in all patients, the endometrial biopsy for one patient, S.M., revealed secretory endometrium (ovulation plus nine days). Previous to visiting this institution, the patient with chronic pelvic inflammatory disease underwent ineffective ovarian wedge resection for a polycystic ovarian syndrome. Another patient, D.P., also had wedge resection failure. All the women with polycystic ovarian disease had experienced infertility from nine months to six years.

Table III contains the pretreatment menstrual pattern, the separate dosages given as well as the ovulatory or anovulatory results of the cycles in patients treated for polycystic ovarian disease.

One patient exhibited no obvious etiological factors to explain the secondary amenorrhea and in the other patient, the diagnosis of premature menopause was made. This patient was a 36-year-old woman and presented with the chief complaint of infertility and secondary amenorrhea. Her menarche was age 13 and her menses were regular every 28 days until age 28 or 29 when irregular menses occurred. Menses were inducible with oral contraceptive pills. However, due to low endogenous estrogen levels, Delalutin was not successful in causing withdrawal bleeding. The 17-ketosteroids and 17-hydroxysteroids were found to be normal. Culdoscopy showed atrophic and sclerotic ovaries.

She was treated for two cycles with long doses of Premarin accompanying Clomid, 50 mg. and 100 mg. for five days each. No ovulation or menstruation followed either cycle.

Primary Amenorrhea

A. Hypogonadotrophic-Hypopituitarism

Of five patients with primary amenorrhea, we were fortunate to study two women with hypogonadotrophic-hypopituitarism. The first patient was one of a group of children who apparently have the same condition. These included both males and females. Our patient was a 19-year-old female and was an example of primary amenorrhea and eunuchoidism. She demonstrated no secondary sexual characteristics and pituitary gonadotrophins were absent. The remainder of her investigation was entirely within normal limits. She was treated for one cycle with 100 mg. of Clomid for five days and showed no response in menses and/or basal body temperature.

The second patient with hypogonadotrophic-hypopituitarism was a 21-year-old, married woman who had never spontaneously menstruated. Her secondary sexual characteristics were juvenile. Pelvic examination revealed infantile labiae, cervix and uterus. The ovaries were thought to be quite small. The pituitary gonadotrophin level further verified the diagnosis. The patient was treated with 100 mg. of Clomid for five days. No ovulation or menses ensued. However, when placed on subsequent Pergonal and HCG regimen, ovulatory menses did result in this patient.

B. Ovarian Hypoplasia

One 27-year-old, para O, gravida O patient with ovarian hypoplasia was studied. Upon laboratory examination, the 17-ketosteroids, 17-hydroxysteroids and skull films were found to be normal. She was treated with cyclic estrogens and responded with normal menses. When medication was discontinued, the patient did not respond. Upon culdoscopy, both ovaries were not visualized; however, her physical and genetic findings were not suggestive of gonadal dysplasia. A laparotomy was performed in an effort to determine the gonadal structure and small hypoplastic ovaries were noted bilaterally with immature and some mature follicles.

She was given 50 mg. of Clomid for five days on cycle one and no ovulation resulted. The dosage was increased to 100 mg. for five days for the following two cycles with identical results. However, these unsuccessful cycles should not be sur-

PATIENT	PRETREATMENT MENSTRUAL PATTERN	CYCLIC RESULTS AND DOSAGES				
		1	2	3	4	5
S.M.	3-6 months	50 x 5 (?)	50 x 5 (?)			
M.B.	1-3 months	50 x 5 (+)				
R.M.	28-30 days	50 x 5 (+)	50 x 5 (?)	50 x 5 (+)		
S.K.	28-30 days	50 x 5 (+)	50 x 5 (?)	100 x 5 (+)		
B.C.	3-6 months	100 x 5 (+)				
D.D.	1-3 months	50 x 5 (+)				
M.F.	7-12 months	100 x 5 (+)				
D.P.	30 days	100 x 5 (+)				
J.R.	3-6 months	100 x 5 (+)				
W.B.	3-6 months	50 x 5 (+)	50 x 5 (+)	50 x 5 (–)	100 x 5 (+)	100 x 5 (?)
P.L.	3-6 months	50 x 5 (+)	50 x 5 (–)	100 x 5 (+)		
P.U.	6-12 months	50 x 5 (–)				
C.F.	3-6 months	50 x 5 (+)	50 x 5 (?)			

Cycles: + = Ovulation
– = No Ovulation
? = Uncertain

TABLE III

prising because of the histological pattern of hypoplastic ovarian tissue.

In our study of the two remaining primary amenorrheic patients, no positive ovulatory results were obtained. One patient was a 25-year-old, para O, gravida O, white female with the chief complaint of primary amenorrhea. Her menarche was age 18 and this was an induced period. Her endogenous estrogens were absent. Presently she is married and the length of her infertility is three years. The patient received only one course of Clomid (100 mg. for five days) and unfortunately did not return for follow-up care.

Another patient was a 25-year-old single, registered nurse whose chief complaint was that of primary amenorrhea. All laboratory studies were completely normal including a laparotomy which showed follicles and an involuting corpus luteum. No evidence of tuberculosis was found in an endometrial culture or dilatation and curettage examination and the patient was given Clomid (100 mg. for five days). A menstrual period began 11 days post-treatment, but the endometrium was proliferative. She received another trial of Clomid (100 mg. for five days) and no menses followed this treatment. No side-effects from either patients were noted.

Anovulatory Cycles

Two patients, 24 and 25 years of age, both para O, gravida O, presented with normally spaced anovulatory cycles. Both had normal laboratory findings including 17-ketosteroids and 17-hydroxysteroids, skull films, PBI and normal endogenous estrogen production as diagnosed by endometrial biopsy and progesterone withdrawal bleeding.

The first patient began 50 mg. of Clomid for five days and the results of the subsequent endometrial biopsy in this treatment cycle revealed proliferative endometrium. The dosage was increased to 100 mg. for five days for the following two cycles in which she became not only anovulatory, but amenorrheic. Human chorionic gonadotrophin, 4000 I.U., was injected intramuscularly four days after the fourth cycle of Clomid. A rise in the basal body temperature curve and a menstrual period occurred 14 days following on day 22 of the cycle.

The second patient was infertile for three years and had anovulatory menses every 27 days. She was placed on 100 mg. for a five-day cycle on May 31, 1965 to June 5, 1965. At this time, she successfully ovulated. This patient will be further discussed in the pregnancy section of this paper.

Pregnancies

Semen analyses were determined on all but four of the patients' husbands in the study. Of the 27 women that ovulated, four of their husbands were found to be subfertile, the others fertile. Clomid appeared to be responsible for five pregnancies, all associated with fertile husbands. All five of these women conceived within the first three treatment cycles. Four were on dosages of 50 mg. and one was on 100 mg. on the cycle preceding conception. Time of conception ranged from seven to 15 days post-Clomid treatment. Two patients have delivered full term normal infants. One was an oligomenorrhea patient, M. M., who delivered a 3365 gram male uneventfully. A congenital anomaly of a persistent frenulum on the base of the tongue was noted. The other patient, D.G., demonstrated anovulatory cycles prior to treatment and she delivered a normal healthy 3205 gram male 41 weeks after Clomid treatment.

Side-Effects

Nine of 37 patients complained of side-effects with Clomid treatment. Four of these patients had oligomenorrhea, four had polycystic ovarian disease and one had ovarian hypoplasia. The following symptoms were noted:

After six cycles of Clomid and only three successful ovulations, one patient's anxiety caused her to discontinue treatment. However, the establishment of a direct correlation between Clomid and the patient's anxiety is questionable.

Two patients were found to have abnormal ovarian enlargements after cycles one and two with accompanying ovarian cysts and pain. During the first cycle of one of these patients, the left ovary became cystic and enlarged to 3-4 cm. in diameter. The right ovary remained normal. During the second cycle, the right ovary enlarged to 4-5 cm. and the left remained at 3-4 cm. Both ovaries decreased in size after the subsequent cycle. The patient noted severe pain (mittelschmerz) accompanying ovulation.

S.H. became amenorrheic after cycle one.

The vasomotor phenomena of hot flashes were noted by patients during their first two cycles.

Another patient noted slight nausea after cycle two.

One patient had vaginal spotting for about one month after two cycles of treatment.

A most interesting patient was a 25-year-old, white female who had polycystic ovarian disease diagnosed on a culdoscopic examination prior to treatment. It is also interesting to note that her 17-ketosteroids were 28.0 mg./24 hours and decreased to 10 mg. with dexamethasone suppression, although no ovulation resulted. She did not respond to Medrol treatment for three months (June to September, 1965) and was treated with 100

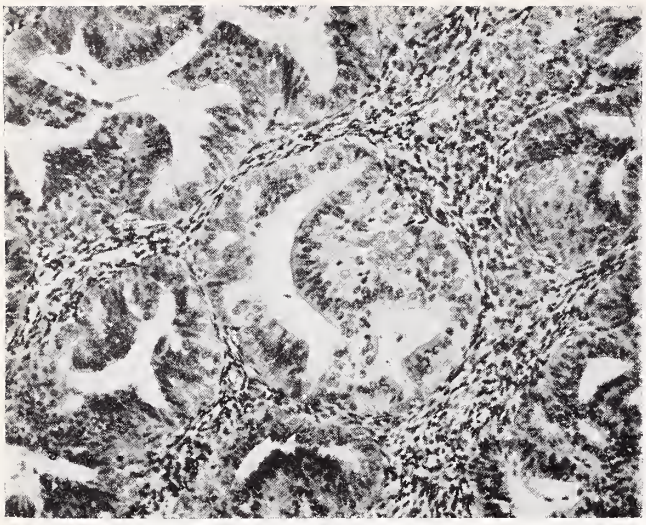


FIGURE 1
PHOTOMICROGRAPH of endometrium demonstrating carcinoma in-situ. (300X).

mg. of Clomid from September 25, 1965 to September 29, 1965. Endometrial biopsy prior to treatment was proliferative and on November 19, 1965, a repeat endometrial biopsy revealed carcinoma in-situ of the endometrium (Figure 1). A total abdominal hysterectomy, wedge resection of the right ovary and left oophorectomy were performed. The pathological examination of the ovaries was consistent with polycystic ovarian syndrome. This observation is most curious since some investigators have reported a regression of this lesion with clomiphene citrate treatment.[5]

Summary

Clomiphene citrate was used to induce ovulation in 37 women. In 16 of the 37 patients, specific diagnoses were made prior to treatment. The importance of intensive endocrine investigation prior to the use of Clomid is stressed in predicting the prognosis of ovulation. The patients with endogenous estrogen production apparently are much better candidates than those without this capability (e.g., hypogonadotrophic-hypopituitarism and premature menopause). Ovulatory results were either negative or questionable in 10 to 37 anovulatory women and thus, 27 patients (73%) responded positively. Five of the unresponsive patients had a diagnosis in which expectancy of ovulation was quite poor. Five patients have become pregnant (13.5%) as of July 18, 1967, and two of these women have delivered single infants uneventfully. Indeed, pregnancy is the true measure of ovulation and perhaps the incidence of ovulation induced with clomiphene citrate may not be as high as indicated by our figures. However, it can also be stated without much question that the prognosis for pregnancy in the categories of patients studied was quite bleak.

The authors conclude that in a small number of infertility patients who are anovulatory, clomiphene citrate is a therapeutic adjunct with minimal side-effects and should be considered after a thorough infertility investigation has been completed.

Acknowledgement

A note of deep appreciation is extended to the William S. Merrell Company for their cooperation and support of this study.

BIBLIOGRAPHY

1. Whitelaw, M. J.: Clomiphene Citrate: Newer Aspects of Its Use in Prevention and Treatment of Infertility, *Fertil. and Steril.* 14:540, 1963.
2. William S. Merrell Company: Clomid (Clomiphene Citrate), a New Agent for the Treatment of the Anovulatory Patient, *Physician's Drug Monograph,* June, 1965.
3. Pildes, R. B.: Induction of Ovulation with Clomiphene, *Amer. J. Obstet. Gynec.* 91:466, 1965.
4. Huffman, J. W.: *Gynec. Obstet.,* page 259, 1962.
5. Kistner, R. W.: Carcinoma of the Endometrium—A Preventable Disease? *Amer. J. Obstet. Gynec.* 95:1011, 1966. ◄

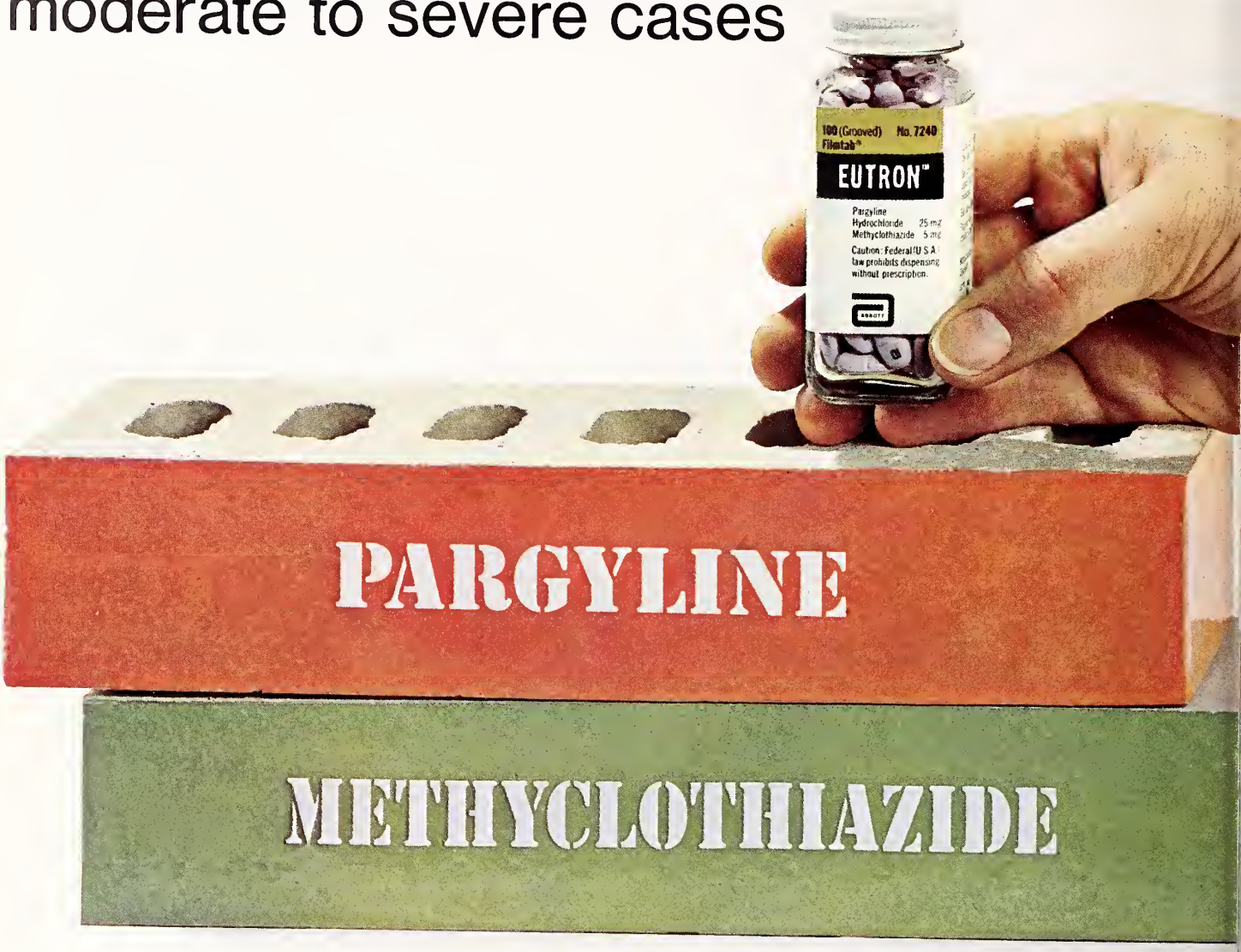
About Our Cover

A wooded spot in Indiana's Turkey Run State Park is featured on this month's cover. This is another of the lovely pictures taken by Henry S. Wood, New Palestine.

Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension

Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE

See Brief Summary on final page of advertisement

801094

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

ABBOTT

TM-TRADEMARK

Case report of proven endometriosis in a woman with a very low supply of endogenous hormones who has been maintained on exogenous hormones for 25 years. The condition is extremely rare. This may be the first reported case.

Endometriosis in a Case of Primary Hypogonadism

A. W. CAVINS, M.D.
Terre Haute

THIS report concerns a case originally diagnosed elsewhere in 1942 as Turner's syndrome with primary hypogonadism when the patient was 17. She was subsequently treated in a cyclic manner by her family physician with diethylstilbestrol, 1 mg. daily for 25 days, and 20 mg. of progesterone on the 25th day. This produced artificial menstrual periods fairly satisfactorily until January, 1961, when she was first seen by me. At that time, at age 36, pelvic examination showed third degree retroversion with the uterus considerably enlarged, its posterior surface rough and tender, and the uterosacral ligaments tender and thickened, especially on the left side. The uterus was quite wide, extending across two-thirds of the pelvis.

The question was whether she had a tumor or only the effects of the exogenous estrogen and progesterone. During the 19 years on medication she had gotten along very well, and had developed fairly normal secondary sex characteristics. In addition, she had been married, and as long as she took her medication, her sexual feelings and performance apparently were satisfactory. Since she was loathe to consider stopping her treatment completely, the dosage of diethylstilbestrol was reduced to 20 doses in each cycle, and the progesterone (Lipo-Lutin) was increased to 50 mg. intramuscularly on the 25th day.

In February, 1961, she was seen again, complaining of intermittent pain in the right "hip" and right iliac region. All of the medication was then stopped, and she was reexamined the following month, at which time she stated that she had felt fine and had had a "very good period" February 27 to March 2. There had been no pain since February 23. Examination in March showed some nodularity in the cul de sac, and some tenderness, but with improvement over the previous condition.

In May, 1961, she was seen again because of trouble with dyspareunia. At that time, the uterus was found to be much reduced in size and retroverted as before, but the cul de sac was still nodular and tender on the left side. Diethylstilbestrol was resumed in dosage of 1 mg. per day, as before, for 25 days, and the progesterone as before (Lipo-Lutin 50 mg. intramuscularly).

In June, the uterus was larger and the cul de sac more nodular and tender. The dose of diethylstilbestrol was reduced. This meant that she took it every other day and then began skipping two days. In July, it was felt that the pelvic condition might be slightly improved.

In October, 1961, she was again seen because of pain in the right side when taking diethylstilbestrol. She stated that diethylstilbestrol caused a full feeling in the rectum. In November, 1961, she had bleeding from the 9th to the 16th, with mild pain after that time. The cul de sac was full of nodules. An x-ray was taken of the lumbar spine, of the pelvis, and of both hands. It showed marked generalized osteoporosis. The diethylstilbestrol was changed to Tylosterone, one tablet daily, and on December 23, 1961, she stated she had much less pain than on the plain diethylstilbestrol. Examination that day showed a bloody discharge, and the mass still present in the posterior pelvis. She was given another dose of Lipo-Lutin 50 mg. intramuscularly and was scheduled for dilatation and curettage. This was done January 11, 1962, under general anesthesia at Union Hospital, Terre Haute. Bimanual examination at that time showed retroversion, third degree, with the uterus a large normal in size, and nodularity in the cul de sac, especially near the attachment of the left uterosacral ligament. The uterus was found to be 3½ inches deep, but very little tissue was obtained on curettage. Nothing was palpable in either adnexal region. The pathological diagnosis was: "Bits of hypoplastic proliferative endometrium showing focal stromal fibrosis." Diagnosis at that time was primary hypogonadism and probable endometriosis of the pelvis.

She was continued for a short time on Tylosterone and Lipo-Lutin, but in March, 1962, she complained of

the growth of facial hair of a few weeks' duration. This was found to be slight, but she also had a small amount of hair in her ears. The cul de sac was quite rough and tender again, and the posterior surface of the uterus was also rough. The Tylosterone was stopped and her colon was x-rayed in April, 1962. This showed no evidence of intrinsic lesion or extrinsic pressure. About this same time, smears for sex chromatin were made from the mouth. No sex chromatin was found. Blood calcium was 8.9 mg. %, phosphorus 2.4 mg. %, alkaline phosphatase 1.6, and acid phosphatase 0.6 Bodansky units. She was kept on a reduced dosage of diethylstilbestrol (0.5 mg.) and was also given calcium lactate because of the osteoporosis. After May, 1962, the diethylstilbestrol was reduced to 0.1 mg. daily the first 25 days with Lipo-Lutin 50 mg. intramuscularly at the end of that course.

She was not seen from June until August, 1962, at which time she said she had not had any menstruation since January. The dosage of diethylstilbestrol was increased to 0.2 mg. daily and she was to take Norlutate 5 mg. daily for five doses at the end of each 20 doses of diethylstilbestrol. In October, 1962, she stated that in late August, she had bled "just a spot." However, she had experienced severe "pelvic pressure" again and had stopped the diethylstilbestrol on this account, but resumed it later. After another month of this, she had the "pressure" again and was found to still have third degree retroversion with the uterus entirely fixed and with nodularity again in the cul de sac, plus considerable tenderness. At that time laparotomy was discussed, and in December it was decided to proceed with it.

On January 8, 1963, two years after I first saw her, I performed total abdominal hysterectomy, double salpingo-oophorectomy, and appendectomy at Union Hospital. The

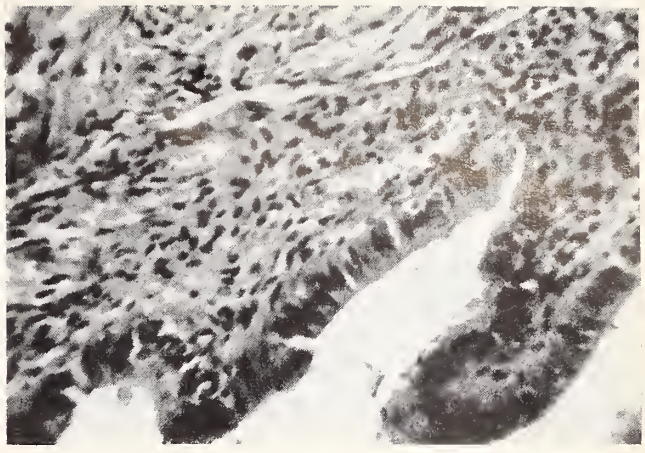


FIGURE 1
ENDOMETRIOSIS in ovarian ligament (Union Hospital Pathology Lab # Su63-63).

uterus was found to be enlarged and its posterior surface was scarred in two places in a puckered manner, typical of endometriosis, and it also had the appearance of adenomyosis. The cul de sac showed scarring, and the rectum was adherent to the back of the uterus on the left side. The tubes were apparently normal, but the overies were rudimentary. The appendix was free in the right iliac fossa. The gallbladder was normal to palpation, and the kidneys were normal in size. The pathological examination showed the uterus to be 9 x 5.5 x 4 cm. The serosal surface was somewhat roughened. The endometrium was thin. The myometrium measured up to 3 cm. in thickness, and contained many trabeculated areas. There were no circumscribed tumors. Fallopian tubes measured 7 x 0.3 cm. each. The lumens were empty. There was a small hydatid cyst, 1 cm. in diameter attached to the fimbriated end of the left tube. The ovaries were very small, measuring 18 x 12 x 4 mm. and 20 x 6 x 3 mm.

Microscopic examination of sections from the cervix showed in places a moderate dysplasia of the squamous epithelium. Subepithelial layers were infiltrated with lymphocytes, and some of the glands showed a transition in their lining from columnar to squamous type. There was no evidence of carcinoma. The endometrium was in a proliferative phase. Numerous typical endometrial islands were scattered throughout the myometrium, and some of them were present on the serosal surface. A few glands of endometrial type were seen on the outer surface of the right ovary. Both ovaries contained many primordial and atretic follicles. There were scattered accumulations of lymphocytes in both ovaries. The Fallopian tubes and the appendix showed no evidence of inflammatory infiltration, although the lumen of the appendix was obliterated in the distal half. The pathological diagnosis was: "Diffuse adenomyosis. Serosal endometriosis. Endometrial implant of the right ovary. Chronic endocervicitis with focal dysplasia of the squamous epithelium. Bilateral ovarian hypoplasia. Small hydatid cyst of the left tube. Fallopian tubes and partially obliterated appendix."

Discussion

On physical examination, this patient appeared to be fairly well developed and nourished, weighed 122 pounds, and was 65 inches tall. There was no webbing of the neck. The general examination showed nothing really abnormal, and the pelvic examination showed the conditions mentioned above. In her past history, she had originally been diagnosed at a large clinic elsewhere as Turner's syndrome, but a communication from her doctors there states that in retrospect she probably was not a case of Turner's syndrome, but one of hypogonadism. They did a curettage on her in 1955, because

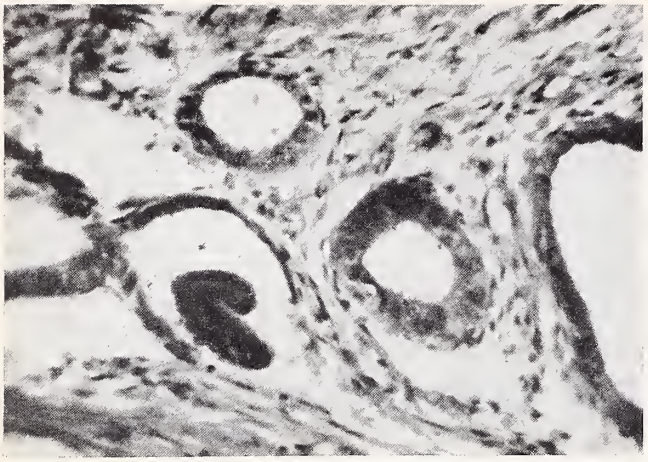


FIGURE 2
ADENOMYOSIS (Union Hospital Pathology Lab # Su63-63).

of irregular bleeding. The operative note indicated no overies were palpable at that time, although the uterus was sounded to 2¾ inches. Microscopic examination of the tissue showed "atrophic endometrium of a cystic type with lipophage infiltration." Their records further indicate that when she was seen at age 17½, she had not begun to menstruate. There was evidence of an elevation of FSH and deficient pubic and axillary hair development as well as lack of breast development so that it was undoubtedly "evident hypo-ovarianism."

A communication from her family physician states that "at the time of her original examination, she had never had a menstrual period. She was small and child-like in appearance, with no secondary sexual characteristics. Pelvic examination revealed an infantile uterus and external genitalia. Excretion studies and vaginal smear indicated the diagnosis of primary amenorrhea.

"On therapy of cycles of estrogen by mouth and progesterone by injection, she was induced to enlarge the uterus, obtain secondary sexual characteristics and normal growth, cyclic menstrual periods and a happy married life."

Following operation, she did very well and was discharged from the hospital on diethylstilbestrol 0.5 mg. daily but *no progesterone* was given. She was seen in February, in March, and again on April 30, 1963. At that time, she had a small ulcer on the left ankle just below and behind the external malleolus. Examination by a general surgeon showed, in his opinion, evidence of varicosities of the left leg with past ulcers. He thought that she probably should have saphenous ligation and low ligations on the left, and at some time in the future, she might possibly need a sympathectomy. Kenalog Cream was prescribed for the ulcer as a local treatment. On September 27, 1963, the ankle was healed, and she was doing well in general, — still on diethylstilbestrol 0.5 mg. daily. She also was continuing to take calcium lactate ten grains three times a day.

She was seen August 7, 1964, at which time the pelvic examination was negative. She appeared to be doing well on the same dosage of diethylstilbestrol, she looked healthy, and her posture was good. I did not see her again until January 23, 1967, at which time she was still taking diethylstilbestrol 0.5 mg. daily. In the previous three or four months, she had had some trouble with edema of the left foot, for which her family physician had given her Hydrodiuril. She also stated that in March, 1966, she had shown slight hematuria and that a urologist had done a cystoscopic examination, x-ray examination and also urethral dilatation. His diagnosis was: "Urethral stenosis. Cystitis. Nephroptosis with calcified area over left adrenal. Pyelonephritis, right."

Examination January 23, 1967, showed mild thickening in the old cul de sac area, and one hemorrhoid. The left ankle showed no ulceration, but she had two areas of unhealthy skin there, one lateral and one medial. The breasts showed no tumors. She was told to continue the diethylstilbestrol 0.5 mg. six days per week and also to see the surgeon again about her ankle.

Summary

This case is presented as being of special interest in regard to the pathogenesis of endometriosis. We have here a woman with definite hypogonadism and primary amenorrhea who almost certainly had never ovulated to the time when she began to receive exogenous hormone therapy. After 19 years of such therapy, plus two years of modified therapy, she was found at operation to have endometriosis, — in ovary, uterus, and cul de sac. I have never heard of a case of hypogonadism developing endometriosis; neither have I ever seen any evidence of endometriosis in a case of Stein-Leventhal syndrome.* I feel that the

*A letter from Mrs. Emma Fosdick, Research Associate, Archive-Library Department, American Medical Association states: "I am unable to find any information in recent medical literature on endometriosis produced by exogenous estrogens or progesterones." In another letter she states: "We have conducted a search of the medical literature for the past ten years, and have been unable to identify a case report of endometriosis occurring in a patient with Stein-Leventhal syndrome."

long continued use of exogenous estrogen and progesterone must have had something to do with its production here. Of course, the circumstances and known data in this case do not give any clue as to whether the endometriosis was produced by reflux through the tubes during artificial menstruation or to some other mechanism. However, it may raise the point as to whether a lack of ovulation in the presence of these hormones has anything to do with the process. If this were true, we would then have to answer the question as to how a woman with functioning ovaries who has developed endometriosis *spontaneously* could have produced progesterone without ovulation. Thus, the lack of ovulation in this patient was evidently compensated for by the progesterone which she received over the period of 19 years, along with the estrogen. Furthermore, the progesterone seems to have been an important factor in the continuation, if not in the production, of this woman's endometriosis. She took diethylstilbestrol *without* the progesterone for four years following operation, with no evidence of recurrence of endometriosis.

This finding agrees with clinical experience in cases of spontaneous endometriosis treated after hysterectomy and castration with estrogen alone (no progesterone) without inducing recurrence of endometriosis.

Acknowledgement

My sincere thanks to Drs. L. L. Blum and Jack Weinbaum, pathologists, for the photomicrographs. ◄

A. P. and S. Clinic
221 S. Sixth St.
Terre Haute 47801

HARDING HOSPITAL, Inc.
(Formerly Harding Sanitarium)
WORTHINGTON
OHIO

For the Diagnosis and Treatment of Psychiatric Disorders
and with
Limited Facilities for the Aging

GEORGE T. HARDING, M.D.
Medical Director

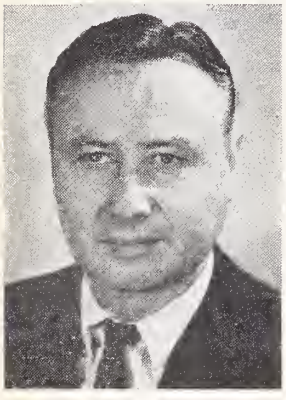
JAMES L. HAGLE, M.B.A.
Administrator

Phone: Columbus 614-885-5381

Management of Acne Vulgaris

VICTOR C. HACKNEY, M.D.
*Indianapolis**

MANY adolescents with significant acne have a somewhat different interpretation of what constitutes a "serious" disease than does the physician. This difference of opinion results from a seeming overconcern of the youngster for his personal appearance and the unavailability to us of a single specific therapeutic agent for the eradication of the disorder. Fortunately, however, the modalities for satisfactory management of all but a few of these patients are available in most physicians' offices. A number of factors contribute to acne, and it is the correction of these contributing factors combined with a logical therapeutic approach which form the basis of the following brief discussion.



Contributing Factors

The frequency with which contributing factors play a significant role in perpetuating acne is not great, but their importance lies in the fact that they are correctable elements.

Drugs, bromides and iodides, certain anticonvulsants, ACTH and corticosteroids may accentuate acne lesions or cause acne-like skin eruptions. Dietary indiscretions, in a few patients, contribute to the problem. Seborrheic dermatitis may add to the inflammatory element. Self trauma, expressed as "picking," rubbing, or resting the face in the hand while reading, all contribute to inflammation and persistence of the lesions. The elimination of heavy, occlusive cosmetics by girls, and greasy hair preparations by boys, often results in improvement of the acne. Persistent or recurrent infections, anemias, and menstrual irregularities in the girls should be recognized and attempts made to diagnose and correct them.

Of all these contributing factors, diet has received the most attention in the past. Occasionally a particular food is found to be an ancillary element in the production of acne, but severe dietary restrictions are not justified. We initially restrict those foods which from past experience have been the most common offenders—chocolate, cocoa, nuts, peanut butter and cola drinks. In addition, if the patient feels that certain foods contribute to his trouble, these are also avoided. Lastly, excessive ingestion of any single food, such as milk, is discouraged.

Therapeutic Measures

The diagnosis of acne vulgaris is simple. We have found it an aid to further classify or grade each individual's problem on the basis of severity of the acne. This rough classification is of help in the selection of therapeutic measures and in discussing prognosis with the patient and parents.

Mild Acne—Variable number of comedones and occasional papules of face. No significant pustular element or scarring. The correction of any contributing factors, facial cleansings and topical medication helpful. Prognosis is good.

Moderate Acne—Comedones associated with inflamed papules and pustules. Marked variability is course with repeated "crops" of papules and pustules. Dietary restrictions, topical medications, and oral, low-dose antibiotics frequently used. Control is usually satisfactory although flare-ups can be anticipated.

Severe Acne—Comedones and inflamed papules associated with deeper pustules often of a boggy, dissecting, indolent character. The neck and upper trunk are frequently involved. Usually necessary to use all therapeutic measures. Difficult to manage.

Topical Medications—Physicians and patients are repeatedly introduced to new acne preparations by several means of communication. Examination of their contents, however, usually reveals the presence of older, familiar medications, sulfur, salicylic acid and resorcin, and local antibacterial agents in various vehicles. Since the use of any of the effective topical medications results in drying and superficial peeling of the skin, the physician need only familiarize himself with a few; their strength and frequency of application depends upon the individual's response. Some are tinted and many girls with moderate acne prefer to use them as a cover.

In youngsters with mild acne we frequently use astringent lotions containing 1-3% salicylic acid in alcohol 70% applied twice daily. Where satisfactory drying is not achieved, lotio alba (N.F.) is added at bedtime. The choice of one of the numerous sulfur-resorcin containing preparations for use in the management of moderate acne will depend upon the concentration of

* Professor and Chairman, Department of Dermatology, I.U. Medical Center, Indianapolis 46202. Also Clinical Director of Dermatology, Marion County General Hospital, Indianapolis.

those substances needed to achieve exfoliation when applied two or three times a day. Some of these proprietary preparations are Acnomel, Resulin Lotion, and Sulforcin Lotion. Benzoyl peroxide-containing local medications (Benoxyl, Vanoxide) are also useful local drugs; particular attention should be paid to excessive drying and irritation of the skin with their use. In poorly controlled, severe acne, Vleminckx's solution (N.F.), sulfurated lime solution, may prove beneficial where other topical medications have been ineffective. It is disagreeable to use because of its odor and its ability to tarnish metal containers and jewelry. The strength may be varied but initially it is diluted one tablespoon to a glass of hot water and applied as a warm compress for 15-20 minutes at bedtime.

As an adjunct to achieving dryness of the skin, each patient is advised to cleanse the face thoroughly with ordinary soap or phisohex and water three times a day. Excessive scrubbing is discouraged. Frequent shampoos are usually necessary to control oiliness or associated seborrheic dermatitis of the scalp.

Other Local Measures

1. The intralesional injection of 0.1 to 0.2 ml of insoluble corticosteroid into boggy, inflamed, cystic lesions has proved useful in hastening their involution. Only small amounts of this drug should be used in an effort to avoid the temporary atrophy which may occur with their use.

2. Erythema doses of ultraviolet light, with its subsequent peeling effect, may be used although the results seldom appear as beneficial as that achieved by natural sunlight exposure.

3. The removal of comedones, and the surgical drainage of cystic lesions, if done at all, should be performed cautiously.

Systemic Medications

Antibiotics. The well-established clinical observation that small doses of broad spectrum antibiotics are helpful in many patients with moderate and severe acne now has a partial rational explanation. These antibiotics suppress, in the pilosebaceous follicles, resident bacterial organisms whose lipolytic action on sebum results in an increase of free fatty acids; the latter are associated with tissue irritant properties. Clinical improvement with small doses of antibiotics is apparently independent of effect on pathogenic staphylococci and streptococci. We prescribe the broad spectrum antibiotics in doses of 250 mgm four times a day for four or five days; the dose is then reduced to 250 mgm daily. Often it is possible to further reduce the antibiotic to 250 mgm every other day and maintain satisfactory improvement.

Oral Vitamin A. This vitamin is not predictably helpful in the management of acne even though it has a theoretical basis of reducing the hyperkeratosis and plugging of follicular orifices. In the few instances where we give it a trial, it is prescribed in doses of 50,000 units daily for three months with periods off the drug of one week every four weeks.

Hormones. The explicit nature of hormonal changes associated with acne vulgaris is unknown; androgens remain the suspected culprit. Estrogenic preparations do suppress sebaceous secretion and size, although when used in doses large enough to achieve this effect, the side-effects are significant. We no longer attempt to routinely manage acne with this hormone alone. Recent clinical observations suggest that cyclic estrogen-progesterone oral preparations are helpful in some older girls with severe acne responding poorly to other therapy. In those instances where the decision is made to utilize these medications they should be given a trial period of at least three months.

The management of acne vulgaris remains just that—management, not cure, whether the care is rendered by the family physician or medical specialist. The improvement achieved with the modalities available to most of us is usually dependent upon the interest and judgment exhibited by the physician in their utilization. ◄

CLINICOPATHOLOGIC CONFERENCE

Case No. A-12,599

Discussant: Dr. Charles Fisch

A 25-year-old Caucasian, married male was admitted to Indiana University Medical Center on November 17, 1967, because of profound heart failure.

The patient had experienced migratory polyarthritis at nine years of age, which had been diagnosed as acute rheumatic fever. He had known of a heart murmur for several years, though the nature of the murmur was undefined. For approximately the past year he had noted mild dyspnea on heavy exertion, and three months prior to admission had noted transient dependent edema. Three weeks prior to admission he experienced coryza symptoms and a sore throat; his physician administered a single injection of penicillin. Malaise, easy fatigability, and dyspnea progressed. On November 11, 1967, he developed orthopnea, paroxysmal nocturnal edema, severe exertional dyspnea, and dependent edema. Three days later he was admitted to another hospital, where he was febrile to 102° F., markedly orthopneic, and demonstrated a loud diastolic, decrescendo, blowing murmur along the left sternal border, associated with a very hyperdynamic circulation. Hemoglobin was 14.4 gm%, white blood cell count 14,000 rising to 29,000/mm^3. SGOT rose from 180 to greater than 400 units. Creatine phosphokinase rose from 5 to 102 units in two days. BUN rose from 33 to 60 mgm% between the second and third day of hospitalization. Blood cultures were drawn and remained sterile. Digoxin, 1.6 mgm, was administered, but discontinued when a nodal tachycardia (rate, 140) developed. Twenty million units of penicillin and 1 gm of streptomycin were administered on the second hospital day, and the patient was transferred to the Medical Center.

The patient was in acute, severe distress: anxious, semi-responsive to verbal stimuli, and quite dyspneic in the upright position. The temperature was 98° F., respiratory rate 40 and labored, pulse 100 and regular, blood pressure 110/35. Body weight was 133½ pounds. The skin was pale but otherwise normal. Examination of the head, eyes, ears, nose, and throat was normal. Chest examination revealed rales in the bases, but was otherwise unremarkable. The neck veins were markedly distended, so full that pulsations could not be identified. The peripheral pulses were all somewhat hyperdynamic. The heart presented a heaving impulse in the anterior axillary line and a heave along the left sternal border. The first heart sound was normal, the second normally split with an accentuated P_2. A grade II/VI systolic ejection murmur radiated from the second left intercostal space into the carotid arteries. A grade III/VI blowing, diastolic decrescendo murmur was maximal along the left sternal border but radiated well to the apex. A grade II/VI holosystolic, blowing murmur was evident at the apex, along with a prominent third heart sound. The liver edge was depressed 10 cm., but the spleen was not felt. There was no edema. The neurologic examination was normal except for the depressed mental state.

Hemoglobin was 12.6 gm%, hematocrit 39%. White blood cell count was 19,300, with 16% bands, 72% adult neutrophils, 11% lymphocytes, and 1% monocytes. Urinalysis included a trace of protein, a specific gravity of 1.014, and no formed elements. Urine sodium was 4 mEq/l. BUN was 94 mgm%, blood sugar 126 mgm%, and creatinine 3.4 mgm%. Sodium was 124, potassium 5.3, chloride 80, and bicarbonate 18 mEq/l. Bilirubin was 2.4 mgm%, with 2.2 direct.

Chest x-ray demonstrated a grossly and generally enlarged heart, with moderately severe pulmonary vascular congestion. The cardiac silhouette was relatively quiet at fluoroscopy, and aortic pulsations were normal. No valve calcification was seen. Ultrasound cardiography demonstrated no pericardial fluid, but a grossly dilated left ventricular chamber to 11 cm. (Normal < 8 cm). Several blood cultures were drawn and remained sterile. ASO titer was 833 Todd units. The SGOT was 9680 units, and LDH was 10,360 units. Penicillin, 40,000,000 units/day, methicillin, streptomycin and hydrocortisone, 500 mgm/day, were administered and continued throughout the hospitalization. Ethacrynic acid, 100 mgm, was administered intravenously on admission. Digitoxin, 0.1 mgm, was given for two days.

Within two hours of the administration of the ethacrynic acid, the patient had diuresed 925 cc of urine

and was quite improved; reasonably alert and responsive, only moderately dyspneic, and all arterial pulsations had increased in forcefulness.

The patient had further improved symptomatically the next morning. Electrocardiogram demonstrated sinus rhythm and very poor R-wave progression across the precordium unless the precordial electrodes were placed two interspaces below the conventional locations. BUN was 109 mgm%, sodium 127, potassium 4.2, chloride 80, and bicarbonate 30 mEq/l. Urinalysis was unchanged. The urinary output was 2905 cc the first day and 3600 cc the second day of hospitalization. The weight was 126½ pounds.

On the afternoon of November 19, 1967 (hospital day #3), the patient had obviously gradually deteriorated despite an additional diuresis of 500 cc: he was dyspneic and tachypneic sitting upright in bed with loud rales and wheezes in both lung bases; the carotids were bounding, but the extremities were cold and the distal pulses barely palpable; the blood pressure had fallen; the neck veins were markedly distended, and a systolic expansion wave was discernible; the precordial gallop was more prominent and the precordial pulsation described as "flabby"; the cardiac murmurs were unchanged. Morphine sulfate and ethacrynic acid, 50 mg intravenously, and high pressure IPPB were administered, and within an hour the patient was distinctly improved symptomatically and with an obviously improved peripheral circulation.

The next morning the patient developed a supraventricular tachycardia of approximately 180/minute. He became dyspneic, and again peripheral vasoconstriction was evident. The Valsalva maneuver, carotid sinus massage, intravenous Neo-Synephrine, and synchronic AC countershock (25 m volt) did not alter the rhythm. Diphenylhydantoin, 250 mgm intravenously, was administered, and six minutes later the rhythm converted to sinus. He improved symptomatically. The BUN was 145 mgm%, creatinine 3.4 mgm%, sodium 140, potassium 4.2, chloride 82, and bicarbonate 30 mEq/l. Urinalysis revealed a trace of protein, but was otherwise normal. His weight was 120½ pounds. That evening he again developed a supraventricular tachycardia (a double tachycardia of paroxysmal atrial tachycardia at 200/min and nonparoxysmal nodal tachycardia at 140/min). The previous measures were unsuccessful in conversion, but a second administration of diphenylhydantoin resulted in conversion to sinus rhythm.

On the morning of the fifth hospital day, the patient was much less responsive and gradually became semi-comatose. His lungs were clear and he did not appear dyspneic. His circulatory system seemed slightly improved. BUN was 108 mgm%, creatinine 3.6 mgm%, sodium 149, potassium 4.7, chloride 85, and bicarbonate 39.5 mEq/l. Arterial pH was 7.61, pCo_2 51 mm. His weight was 122 pounds. His measured blood volume was 1500 cc in excess of his calculated volume by body weight. Arginine hydrochloride was administered.

BUN rose to 220 mgm% and the patient remained alkalotic and semi-

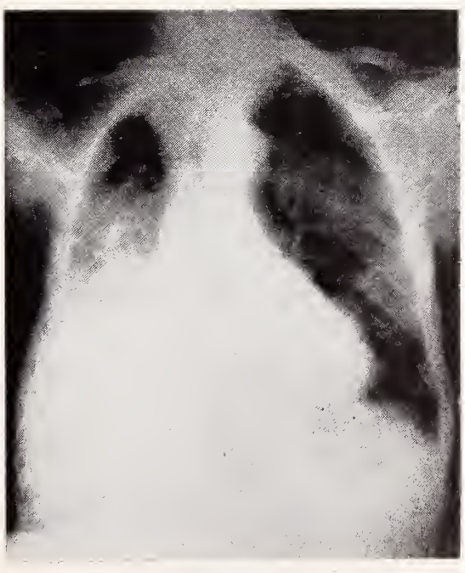


FIGURE 1
FIRST x-ray shows enlargement of the heart.

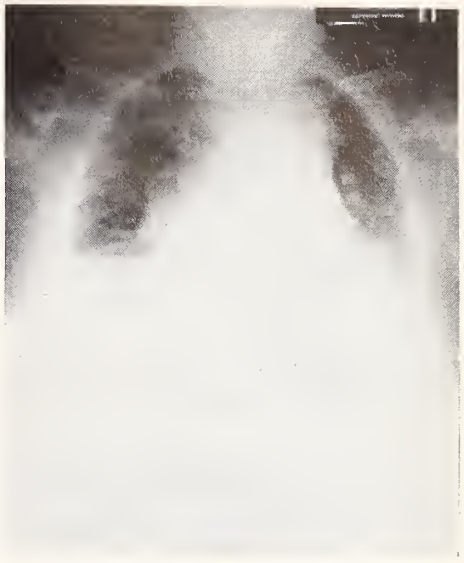


FIGURE 2
SECOND x-ray shows increasing enlargement of the heart.

comatose, without any obvious change in the cardiovascular system. Peritoneal dialysis was instituted, but the patient remained comatose, and the BUN remained around 200 mg%; little additional fluid was removed. The pH was reduced to 7.46 and the electrolytes were near normal. The blood pressure dropped and could not be maintained with isoproterenol. The patient died on the sixth hospital day.

DR. HUNTER A. SOPER: The protocol describes a man who came in with what was called profound heart failure and it certainly sounds as if this was correct. The history is quite well outlined and we'll not bother to go through it right now. Dr. Fisch will cover some of the elements of this as he goes through his discussion.

We'll start off by discussing the x-rays.

DR. ROSCOE MILLER: We have two x-rays (Figures 1 & 2) which show an increasing enlargement of the heart. One of the films also shows pulmonary vascular congestion. This increase is in the right middle lobe, as on these films. This is not a fluid level but edema, we believe, in the right middle lobe, and the configuration of the heart

is most compatible with pericardial effusion but not pathognomonic of it. There is no question in our minds that the films show pulmonary congestion or edema. We do not see pleural effusion, but we do suspect pericardial effusion and certainly edema of the right middle lobe, progressing throughout the patient's hospital stay.

Are there any questions?

DR. SOPER: Granted that this fellow was really sick and that the question of pericardial effusion sometimes comes up on someone who is very sick, with findings not dissimilar to this, how might the x-ray man be able to help us with this problem?

DR. MILLER: A phonocardiogram will do a better job, I believe, in detecting pericardial effusion than x-ray. There are certain tests that are done by x-ray, one of which is the injection of CO_2 with the patient in the left lateral decubitus position to see if there is an increase in the size of the heart; however, experiments on dogs will show that the heart will tend to float up — the gas will cause the heart to float up on fluid in the pericardial sac, and this is not the best test. I believe that one should use those tools that will give you the best results most of the time, and I would think that a phonocardiogram would be the best method for detection of that. There are other ways: One can inject contrast material into the pericardial sac, and one can also try to aspirate pericardial fluid.

DR. SOPER: Obviously the physicians who took care of this patient had an extremely difficult time. They tried hard and they failed. They were uncertain, I am sure, of their standing as far as diagnosis goes, and I am sure that this is one of the reasons that they wanted to see what Dr. Fisch could come up with as he tied into this extremely difficult protocol.

DR. CHARLES FISCH: I think those of you who have read the protocol will realize why I am obligated to thank Dr. Joe Noble for asking me to discuss this protocol. In the first place, I would like to ask one question of Dr. Miller. Is this compatible with just a big heart without this pericardial effusion?

DR. MILLER: I think so. I don't think we can determine it.

DR. FISCH: Would you consider that a big, a medium-big, or average heart?

DR. MILLER: I would think that it would be more than an average heart. I think it's big; I don't think it's nearly as gross as I have seen. I have seen hearts so large they fill both sides of the chest, reaching to both sides of the thoracic cage, so this is a matter of relativity. I think it's a large heart but not an enormous one.

DR. FISCH: I really don't know what's wrong with this patient, and I don't have a definitive answer. As somebody pointed out to me, I'll probably have to listen to myself and then come up with the diagnosis. The only thing that one is sure of here, is that this patient died. It's about the only thing that's certain. This may not be as funny as it sounds. It's the mode of death in this patient that I think is the most important item of the story. We rarely see a 25-year-old man die as rapidly as this patient did. So this is probably the most leading part of the history. The management of this patient, from what I can gather from this history, was exactly as one would expect. If this were not a CPC and the pathologist did not have the answer, this would be considered a pretty straightforward case of a patient who probably had rheumatic disease and then developed acute endocarditis and went ahead and died, probably from a perforation of an aortic leaflet. I am sure that this is what the house staff and people who took care of the patient thought of and perhaps they also thought of recurrence of rheumatic fever, because I see that they did treat him with steroids. So, from the standpoint of management, this patient was managed A-1. What he ultimately proved to have I don't know. He would not have what I just mentioned or he would not be presented as a CPC.

The first problem one comes up against that is extremely difficult to resolve and makes the whole discussion kind of difficult is: (1) Was this really a terminal event of a long-standing case of chronic valvular disease? This is number one, and we can't resolve that because we know very little about this patient other than that he had some sort of a murmur and apparently got along quite well because he was able to perform heavy exertion. I rather doubt this possibility.

The second question one likes to know is whether this is a superimposition of a new illness on top of a chronic disease. This is why I asked Dr. Miller about the size of the heart, because if this were a terminal event in a patient with chronic valvular disease, we would expect the heart to be somewhat larger than it is here. So we have a man who died at the age of 25. He died rapidly and died of heart failure. He had all the symptoms of left ventricular failure: he had dyspnea, orthopnea; he had a history of edema in the past; on physical examination he had a large heart; he had a gallop; he had rales in the chest; he had markedly distended neck veins; his liver was grossly enlarged; and he had obvious evidence of heart failure on x-ray.

In addition to heart failure, however, he probably had peripheral vascular collapse or shock, because as one reads the story, one finds that

the carotids were bounding but the extremities were cold and the pulse was barely palpable; there was peripheral venous constriction with marked distension of the neck veins. In this frame of reference, I'd like to dispose of the SGOT and LDH of 10,000; I think this was due to a combination of heart failure and shock. SGOT and LDH elevations to 10,000 have been described in these conditions. I have seen them even higher than that. So I think that this part of the transaminase can be dispensed with now. I will come back, however, to the CPK and SGOT which rose the first two days of hospitalization in another hospital. So far, we have a man who dies of heart failure, in combination with shock, and I think that the renal problem was most likely secondary to his congestive heart failure.

Now the next question arises: What is the underlying disease here? I mean, what is the primary cardiac disease? The physical findings are of some help. The patient had a wide pulse pressure — 130/30; he had a normal S-1, a loud P-2. He had a grade 3/6 diastolic blow, a grade 2/6 ejection murmur. Interestingly enough, the ejection murmur was located in the left 3rd interspace rather than in the right, but one would expect it with an aortic ejection murmur. It did radiate, however, into the carotids and there was a grade 2/6 pansystolic murmur. The heart was grossly enlarged with both a left and — significantly — a right parasternal heave. So, of the physical findings which tend to lead one into some unusual things here are the markedly distended neck veins (this was pointed out twice in the protocol); once they did not pulsate, on the second time they pulsated slightly. I tend to assign considerable significance to the parasternal heave and the loud P-2. These features suggest to me that the patient had developed some evidence of right ventricular hypertrophy, and I'll try to explain that later.

With these kinds of physical findings, what is our diagnosis? Obviously he had aortic insufficiency, which was probably rheumatic in origin, because of the history of acute rheumatic fever in the past. Aortic insufficiency can also be congenital in origin. It could be bicuspid. I like to bring up the problem of aortic insufficiency due to sinus of Valsalva aneurysm, which is rather rare, but there are some things that would make me think that this is worthy of discussion in this particular case. Dissection of the aorta with development of aortic insufficiency is something one considers in this type of situation where the patient dies suddenly with a wide-open AI. But there is very little evidence to support aortic dissection.

In the first place, this was a young man with no evidence of any sort of congenital anomalies which would predispose to dissection of the aorta. There was no history of pain, and a history of pain is obtainable in better than 95% of these patients; so there is nothing much to go along with dissection of the aorta here. The only thing that made me even wonder about it was the fact that the carotids were bounding at the time peripheral arteries were barely palpable, and one other thing that might go with this is the renal shutdown, which is occasionally seen with dissection of the aorta. However, in the absence of pain in a man who has no predisposing reason for dissection, such as hypertension or Marfan's, I would like to just mention it as a possibility but dispose of it quite promptly. There is no reason to think that this man had a wide-open traumatic aortic insufficiency. And finally, I would like to point out that one develops a wide-open insufficiency and dies quite rapidly from superimposed infections which either destroy or perforate the aortic cusps.

So of all the possibilities, I would like to retain the possibility of an aortic aneurysm or something related to a sinus of Valsalva aneurysm, and the problem of aortic insufficiency with superimposed infection. This would be fairly simple if it weren't for another problem: that systolic and diastolic murmurs don't always indicate aortic insufficiency, even if the diastolic murmur is of 3/6 or even 4/6. One has to consider some other lesions which would produce almost the same sort of physical findings on auscultation. Patent ductus arteriosus patients have to-and-fro murmurs and if one develops pulmonary hypertension, the nature of the murmur changes and there may be a pause between the systolic and diastolic murmur. Another lesion which commonly produces these types of physical findings, namely the systolic and diastolic murmur, is a ventricular septal defect with a nonsupported aortic cusp. Now we have seen a number of these. Dr. Feigenbaum has catheterized a number, and they sound just like ordinary plain aortic insufficiency. This patient significantly did have a pansystolic murmur and a normally splitting second sound, so the possibility of a VSD with a nonsupported aortic cusp can be considered. Another lesion is a coronary arteriovenous fistula which would give one a continuous or a systolic and diastolic murmur which cannot be differentiated from an aortic insufficiency. Finally, a lesion which causes dramatic death in very short order, with markedly distended neck veins, with a right ventricular heave, is a rupture of the sinus of Valsalva into the right ventricle. It produces the same sort of physical findings.

Now, I can do all this simply because we don't know what the physical findings in this boy were prior to admission to our hospital and to the hospital three days prior to admission to IUMC. At this point I would like to ask just one question of Dr. Noble: What was the blood

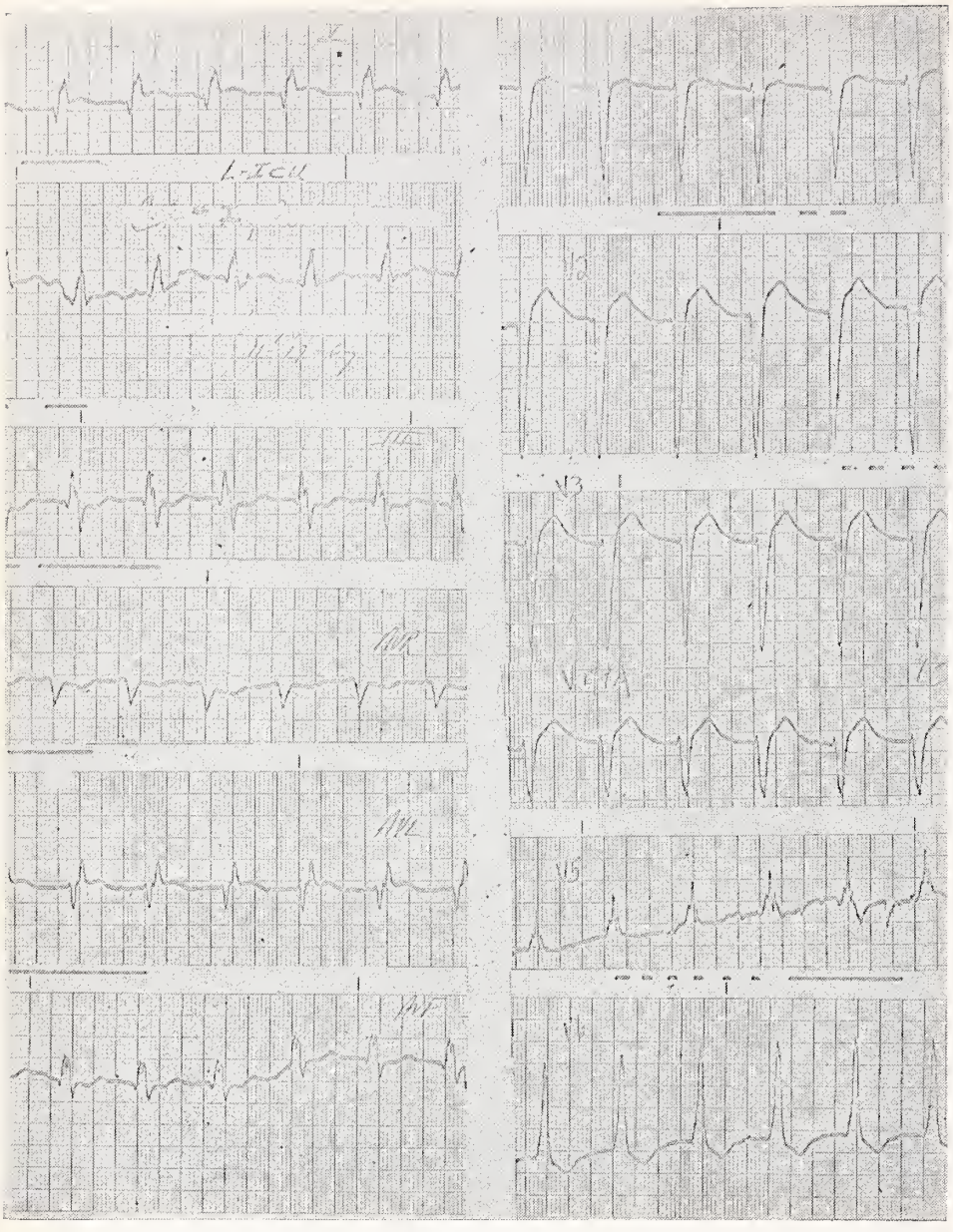


FIGURE 3
ELECTROCARDIOGRAM showing that the rhythm is one of nonparoxysmal nodal tachycardia.

pressure at the time of admission to the local hospital before he came here?

DR. JOSEPH NOBLE: A very wide pulse pressure.

DR. FISCH: So from day 1 he had a wide pulse pressure. There is no reason to think that there is dramatic change in his blood pressure or any physical findings as far as you know?

DR. NOBLE: Not from the time of admission to the other hospital.

DR. FISCH: So he was already widely dilated at that time. What do we have so far? We have a rapid death in a 25-year-old man who obviously died of heart failure with an accompanying shock and who could have a number of organic lesions. The ones we would like to settle on really are ordinary rheumatic AI, a VSD with a nonsupported cusp, and I'd like to think about a ruptured sinus of Vaisalva.

We must also ask the question of whether this illness was long standing or of short duration. There are some physical findings that make me think that this boy was sick for some time prior to the onset of this acute illness; namely he had a lifting left and right ventricle, and one doesn't usually develop this type of physical finding for at least three to six months at the earliest. So I'd like to think that he had an illness which lasted for some time prior to his terminal event. The next question I would like to ask: Which of the lesions which I have discussed so far really can produce heart failure and death on hemodynamic cause of failure, for example, in plain ordinary mitral insufficiency or AI from a heart failure which has a myocardial component other than the effects of stress of a diseased valve. I would like to simply mention that dissection could do it, trauma could do it, infection could do it, and ruptured sinus of Valsalva could. We have already decided that we are not going to be concerned with dissection, we are not going to be concerned with trauma, and we are left with the possibility of an acute endocarditis superimposed on the aortic valve and the possibility of a ruptured sinus of Valsalva.

I believe that the terminal event was not due to a chronic valvular lesion but perhaps to a myocardial factor which was superimposed on something this man has had for a long time. What is it that makes one think that there is a myocardial factor involved other than the one related simply to the chronic valvular disease? The simple point is that one does not see an ordinary aortic insufficiency patient die this way. It is very unusual for a 25-year-old man to die of aortic insufficiency and die this rapidly. In fact, it is most unusual for him to die in this manner from a VSD with a nonsupported cusp or a patent ductus or anything else; so that one has to add something to cause the demise here.

There was a very definite myocardial factor which either was or was not engrafted on a pre-existing lesion and the nature of which we cannot determine at this time because there is nothing in the protocol to give us a hint. What are the evidences for a myocardial component

to this man's demise? I'd like to call your attention to the fact that he had a parasternal lift; a parasternal lift is very often seen in cases other than RVH in people who have myocarditis or some kind of myocardial disease. Why right ventricular lifts are prominent nobody understands, but this is a real physical finding.

There is no reason to think that this boy had anything in the past that would make one think about right ventricular hypertrophy, or cor pulmonale, to account for his right parasternal lift. With this right parasternal lift he had a loud gallop rhythm. So the physical findings support a myocardial component. The enzymes also support a myocardial component; namely, the CPK went up from 5 to 102 in two days, and this, from what I can gather, is a fairly specific sort of an enzyme that is found in muscle, brain and heart tissue. It is usually not affected by changes in the liver. This is a respectable rise that is within the range of a myocardial damage. The SGOT also went up from 180 to 400, which again is in the range that we see with myocardial damage prior to onset of heart failure and prior to the onset of shock in this patient. These other conditions produce a rise up to 10,000. So we have physical findings, we have enzyme changes pointing to myocardial involvement here; and we have, most importantly I think, EKG's which are very interesting and point to a large myocardial component in this boy's problem.

The first EKG (Figure 3) shows that the rhythm is one of nonparoxysmal nodal tachycardia. There are no P waves and the rhythm is absolutely regular. We have assumed that this type of rhythm occurs in three situations: (1) It is due to digitalis toxicity, which may be the case here; (2) It is seen with myocarditis, and it is seen characteristically with rheumatic myocarditis; (3) It is seen with myocardial infarctions. Practically all those described were inferior. So we have a nonparoxysmal nodal tachycardia, which if we play our electrocardiographic statistical game, we are going to focus on digitalis toxicity or myocarditis.

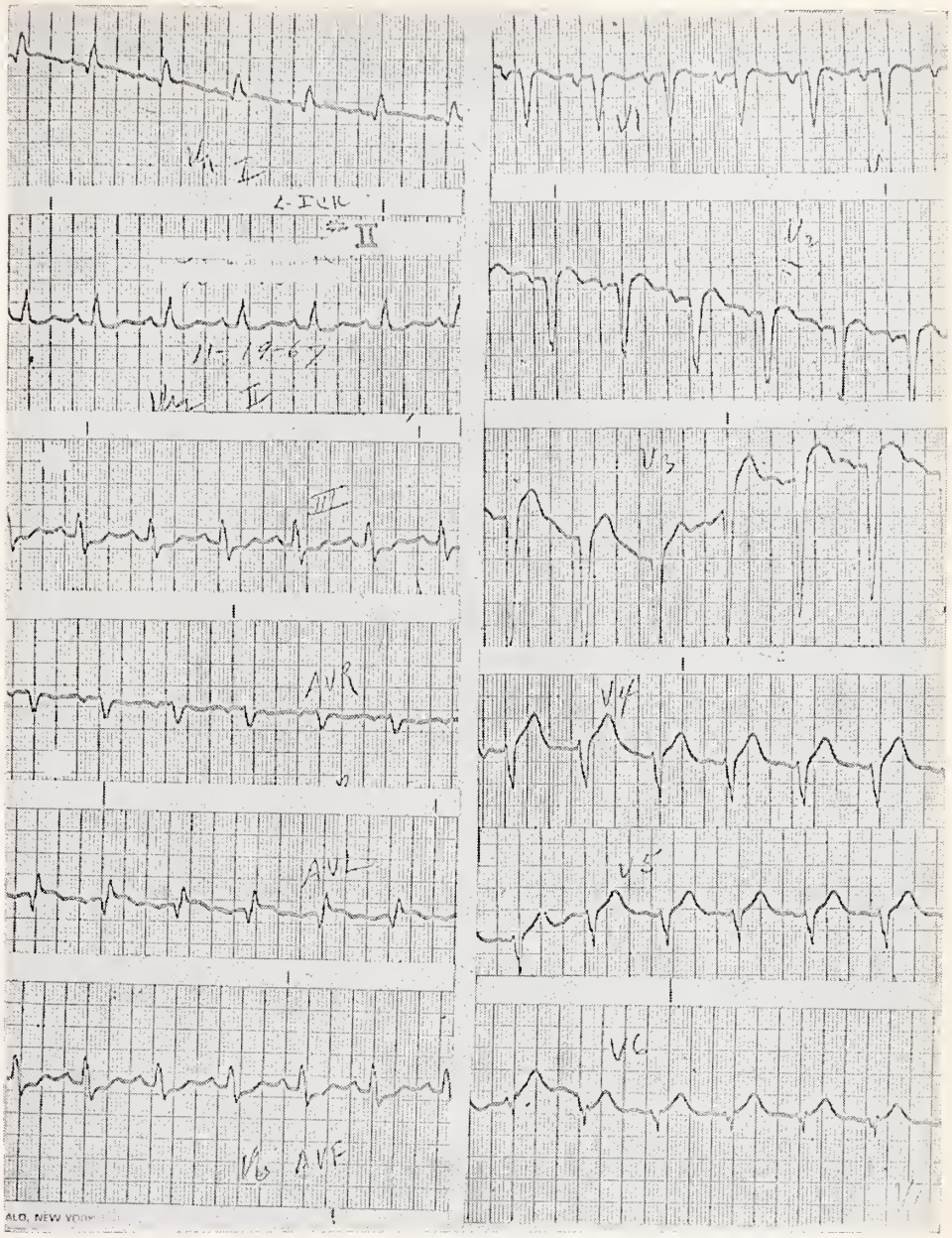


FIGURE 4
THE second EKG reveals the Q wave, the elevated ST segment but this time a sinus rhythm.

Now this boy's BUN was elevated when he was given 1.6 mg of Digoxin, and although it is possible that this produced nonparoxysmal nodal tachycardia, it is very unlikely. These are acceptable doses of digitalis; no subsequent digitalis was given, and I would like to think that this was not due to digitalis toxicity but the nonparoxysmal nodal tachycardia is due to a myocarditis of some sort. The QRS changes are very interesting. The striking thing is a Q wave in Lead 1 in AVL. Q waves are confined again to myocardial infarction or any other lesion which produces death of muscle, such as myocarditis. It has been described in patients with amyloidosis, but the combination of the deep Q wave and the nonparoxysmal nodal tachycardia certainly suggests a myocarditis of some sort. Furthermore, the ST segments are elevated in I and they are elevated in AVL. This again suggests a fairly recent injury

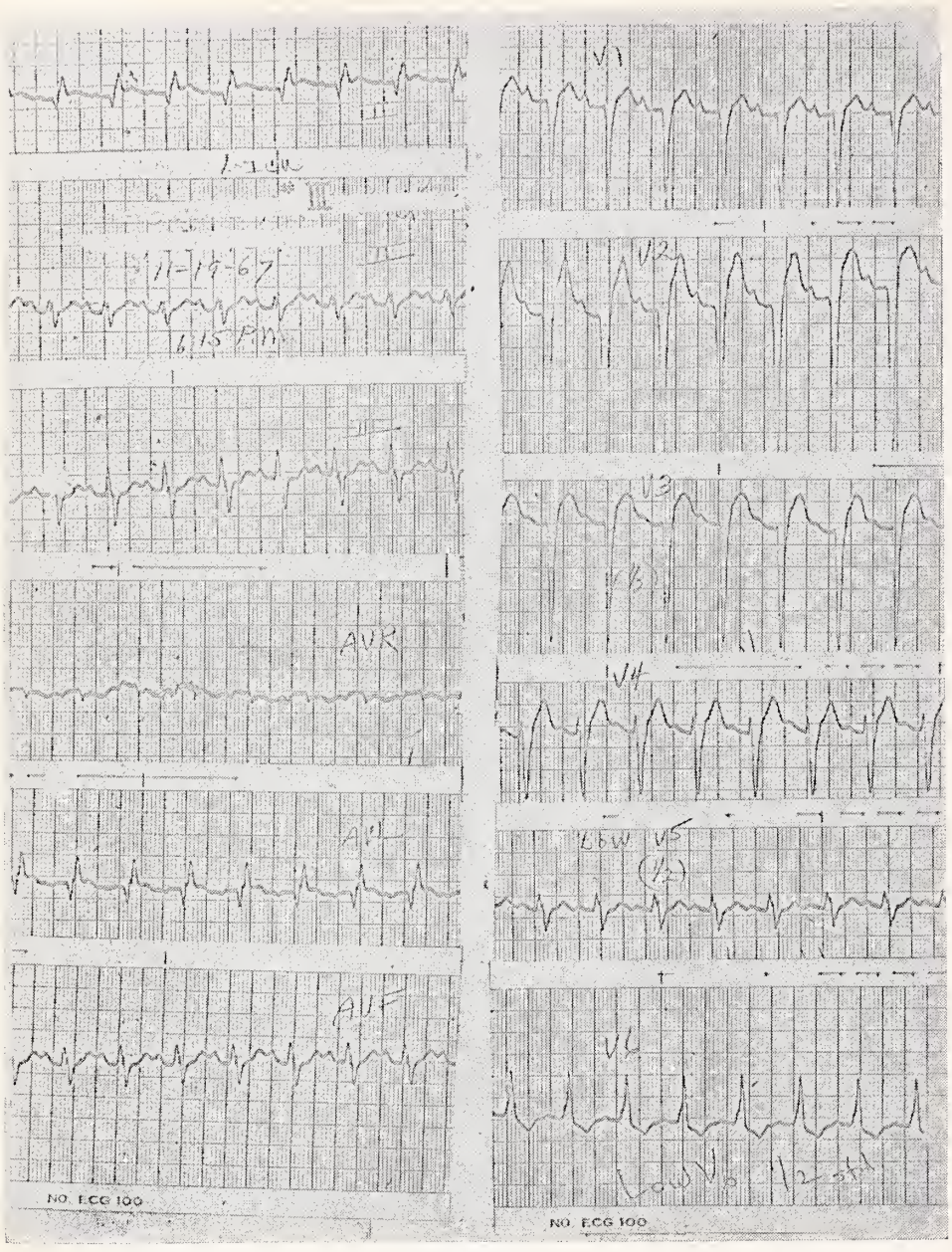


FIGURE 5

ELECTROCARDIOGRAM again shows the Q wave, the elevated ST segment and a marked shift in the axis.

to the myocardium. Most interesting is the shape of QRS. You will note that the QRS is splintered; it is slurred; it doesn't look like right or left bundle — it just looks like a nonspecific conduction defect, and again suggests myocarditis of some sort or diffuse myocardial damage. We do not see tracings like this with chronic valvular disease. We do not see them in congenital heart disease except with subaortic stenosis, which I don't believe this boy had and we see them occasionally in patients with a large VSD.

The second EKG (Figure 4) again shows the Q wave, and the elevated ST segment, but this time a sinus rhythm. I would like to draw your attention to the axis here. You will notice in Lead 2 there is no S wave and the axis would be roughly perpendicular to 3 and be on the positive side.

The third EKG (Figure 5) again shows the Q wave and the elevated ST segment. Now, please note that on the same day there is a marked shift in the axis, indicating interventricular conduction defect which occurred rather rapidly. So all these tracings point to some kind of a rather severe diffuse myocardial disease, and coupled with the physical findings of the RVH, and the elevated enzymes, we must consider a myocardial factor in this boy.

The next question one would like the answer to is what is the myocardial factor in this boy? Here I would like to point out that one can go through the list of 50 or 60 different forms of myopathies that can produce a myocardial factor, but this was an acute illness; this was an illness associated with fever; this was an illness associated with a high leukocyte count and a rapid demise. So I think we can pretty well narrow down our forms of myocardial involvement to three or four which would do this.

The first one obviously everybody thinks about is recurrence of acute rheumatic carditis. In a boy 25-years old, we have the URI about three weeks before he really got sick and died; we have a previous history of rheumatic fever pretty well documented. We had ASO titer of something in the order of 800 or better; we have a nonparoxysmal nodal tachycardia on EKG. So that we have many things in favor of an acute rheumatic carditis complicating an old valvular lesion, assuming this was an old valvular lesion. We have to assume this because this is what the protocol says. I am a firm believer that recurrent rheumatic carditis in a man 25 years old is rare. I have had this going argument now for 10 years in discussion with other cardiology people, and I still firmly believe that a recurrence of this form of malignant, rapidly progressive rheumatic carditis would be most unusual at the age of 25. It would be most unusual since the last episode was at the age of nine. So even though there is much to make you think about a recurrence of rheumatic fever in this patient, I don't believe that this would be my first choice. It is quite possible for acute rheumatic carditis to cause demise in this rapid order if there is consider-

able arteritis involving the coronary with diffuse areas of occlusion, myocardial infarction and death. Those types of lesions have been described and I am sure Dr. Bolinger will have something to say about this.

The next in order of importance is just a plain ordinary viral myocarditis. This cannot be disregarded in this particular patient because the patient started with a sore throat and died in three weeks. This is perfectly compatible with a viral myocarditis, particularly with the right ventricular lift, fever, and the leukocytosis. This would have to be engrafted obviously on a pre-existing wide open AI.

The next possibility which I think is high in order is aortic insufficiency with a secondary endocarditis, with perforation of a cusp and probably the patient's demise in that way. One can list all the ways that endocarditis could kill this patient, but this is one very important lesion to consider.

The fourth lesion in the myocardial group that even needs to be considered is polyarteritis nodosa. Again, it would not account for the AI. It would have to be something that is engrafted on a pre-existing lesion. It would account for all the physical findings. It would account for the rapid course of events, and it would account for the size of the heart and everything I saw. We are left with a wide-open aortic insufficiency and the possibility of recurrence of rheumatic fever, viral myocarditis, or acute endocarditis. I would like to mention one more thing, and then I will quit, and that is a ruptured sinus of Valsalva with a to-and-fro murmur secondary to endocarditis.

If I were treating this patient, and even now after having the CPC and the protocol, I still would think that the number one order of business here is an endocarditis which has to be handled because this is a curable lesion and one hates to see people die with an endocarditis. Since this is a CPC, I would put viral myocarditis as my first choice with the pre-existing chronic aortic insufficiency, and I think I have talked enough so no matter what comes up I might have mentioned it.

DR. SOPER: This discussion, I think, brings out a number of very pertinent clinical questions, and I hope we will have a little time to have some questions here from the group. I think we will go right ahead now to the findings of the pathologist. Dr. Bolinger, do you want to do that and then we will use the remaining time for questions?

DR. GARRY L. BOLINGER: Before discussing specific organs, the serous cavities should be described. A normal amount of clear fluid was present in the pericardial sac, but each pleural cavity contained 100 mls. of clear fluid. Since dialysis had been performed, it should be pointed out that the serosal surfaces in the peritoneal cavity were smooth, and there was no evidence of peritonitis. In addition petechiae were seen within the visceral pleura of each lung and within the epicardium. Most likely these are related to hypoxia.

Figure 6 is a gross photograph of the heart which had a weight of 830 gms. Petechaie are seen in the photograph as punctate dark foci over the anterior surface of the heart near the apex. The tricuspid and pulmonary valves were composed of semitransparent pliable leaflets. The leaflets of the mitral and aortic valves were very firm and rigid. There was deepening with accentuation of the sinuses of Valsalva from the rigidity of the thickened aortic cusps; however no aneurysms in the sinuses of Valsalva were identified. The chordae tendinae of the mitral valve were rope-like. Prior to opening the heart, insufficiency of the aortic and mitral valves was demonstrated by an autopsy technic. The chambers

FIGURE 6
GROSS photograph of the heart.

were generally dilated. The thickness of the wall of the left ventricle was 2.0 cms, and the thickness of the wall of the right ventricle, 0.6 cms., indicating biventricular hypertrophy.

The myocardial fibers were extensively interrupted by rather acellular collagen, suggesting the chronicity of the carditis (Figure 7). The myocardial fibers within these scars are smaller than usual. Sections from all chambers showed the same broad scars and diffuse interstitial colla-

FIGURE 7
ACELLULAR collagen, suggesting the chronicity of the carditis.

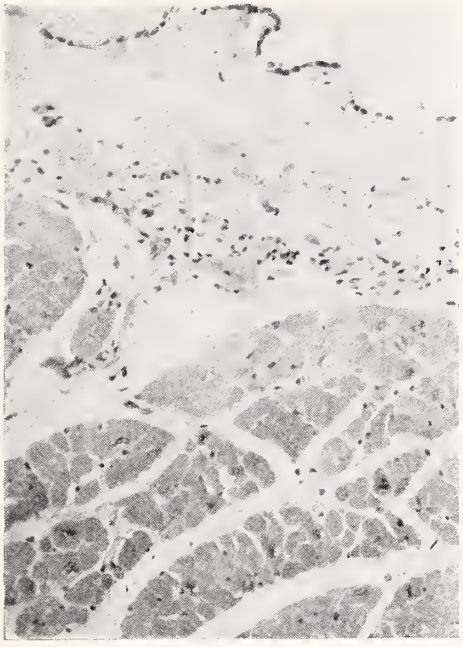


FIGURE 8
FIBROSIS with lymphocytic infiltration of the subepicardial fat.

genization. The fibers which persist were seen to have cross-striations in the cytoplasm mitigating against an acute inflammatory or ischemic process. No Aschoff nodules were encountered in spite of examination of sections of heart where they are known to occur frequently in rheumatic carditis such as the interventricular septum. Sections of the aortic and mitral valves revealed fibrous thickening, and within the dense collagen, scattered lymphocytes and thickwalled blood vessels were seen. Minimally active inflammatory changes present in the heart were limited to the epicardium which was composed of a single layer of cuboidal cells. Fibrosis with lymphocytic infiltration of the subepicardial fat is seen in Figure 8.

The possibility of small coronary artery disease was suggested by Dr. Noble. Dr. James, in his recent article on this subject (*American Journal of Cardiology*, November, 1967) mentioned thromboemboli in small coronary blood vessels and a coronary vasculitis with rheumatic disease. Since this patient's death was rather sudden and possibly related to ischemia of the conduction system by a mechanism suggested by Dr. James, sections of parts of the system were examined by the pathology department. No abnormalities were seen in the SA or AV nodes; the lumina of the coronary arterioles were not occluded by thrombi.

The combined weight of the lungs was 1400 gms. and each had a bronze appearance on the external and cut surfaces. In Figure 9 the changes of chronic passive congestion are seen. The alveolar septa are thickened, and hemorrhages, congeries of hemosiderin-laden macrophages, and a granular proteinoid material can be seen in the alveoli. In still other lung sections small thrombi were seen adhering to the intimal surface of thick-walled pulmonary arterioles.

There was a question clinically of whether this man had glomerulonephritis, but the subcapsular surface of each kidney (wt. of each, 140 gms.) was smooth. In a hematoxylin and eosin-stained section of kidney (Figure 10) a pink-staining granular material was seen in the tubular lumina and this correlates clinically with albuminuria at one time. The glomeruli as seen in the photo are hypercellular. The basement membranes were not thickened in any of the sections, but with the periodic

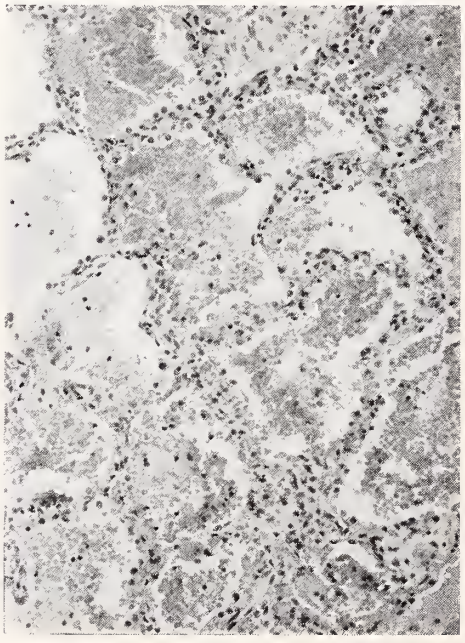


FIGURE 9
CHANGES of chronic passive congestion are evident.

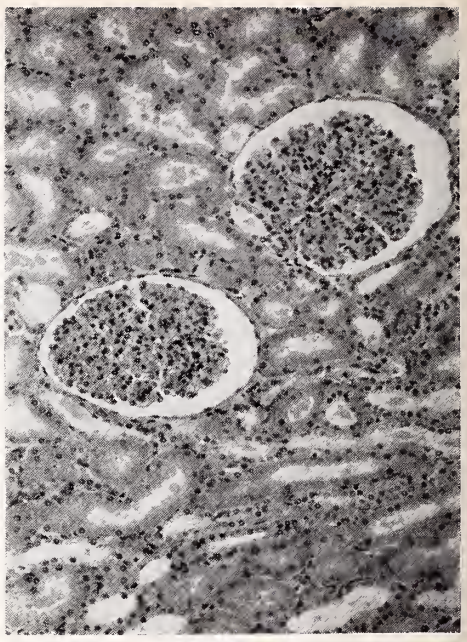


FIGURE 10
A pink-staining granular material is seen in the tubular lumina.

acid Schiff (PAS) staining method, fine PAS positive fibrils were seen deposited in the intercapillary space or mesangium. The renal changes described in this case have been described by many others including Dr. Heptinstall in his text, *Pathology of the Kidney*, in patients with rheumatic disease. Whether the renal change is a manifestation of the rheumatic process or a secondary finding related to pulmonary hypertension is not established with certainty. Dr. Heptinstall reviews the subject and problem well with a discussion of series from Dr. Russell and Dr. Bell, who report varying incidences of this lesion in association with rheumatic carditis. In Dr. Russell's series of 264 cases, 76 had these diffuse hypercellular lesions.

The weight of the liver was 1260 gms.; and the SGOT elevation may be explained by the prominent necrosis of liver cells seen in microscopic sections in the central parts of the lobules (Figure 11); this is frequently a pathologic finding in severe passive congestion of the liver as in heart failure.

In summary, we have a case of diffuse fibrosis of the myocardium. There are fibrotic lesions involving the aortic and mitral valves. There

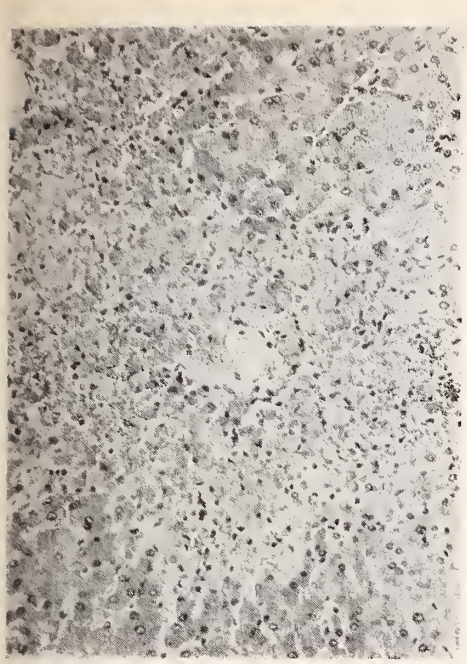


FIGURE 11
PROMINENT necrosis of the liver cells in the central parts of the lobules.

is minimal inflammatory change in the epicardium with changes of severe passive congestion in all the other organs. This pancarditis is consistent with chronic rheumatic carditis, but in the absence of Aschoff nodules, the diagnosis is not indisputable.

DR. SOPER: Well, we are right where we started from. Anybody have any questions he would like to ask either Dr. Fisch or Dr. Bolinger?

A PHYSICIAN: How long does it take an Aschoff body to form?

DR. BOLINGER: There is a very good article on this by Dr. Gardner, who is a connective tissue pathologist basically. He thinks that these things go through a growing phase and a regressing phase, and in an acute insult, they should be present within one week. Many times they continue changing their morphology, sometimes getting larger as other, possibly myocardial, cells coalesce, and I know that this is disputed—whether these are myocardial cells, or whether these are large macrophages; but assuming that they are myocardial cells as they coalesce, they may extend and become much larger and in a period of a month or three months may be quite obvious. They also do disappear many times, in the healed phase of rheumatic carditis. Hence, this is why we think this is possibly rheumatic carditis and we don't have Aschoff nodules left anymore.

DR. SOPER: Could steroids possibly prevent the development of the Aschoff nodule, or the inflammatory cells — the things that we are missing here?

DR. VELLIOS: I think it would abort it but not completely remove it.

DR. FISCH: If you consider this to be rheumatic carditis, is it compatible with a three-weeks story beginning with sore throat three weeks prior to admission and death, or does the size of the heart and the weight of the heart make you think this is a smoldering rheumatic disease of many years duration?

DR. BOLINGER: I believe the changes that we see in the heart, the diffuse myocardial element particularly, would suggest that this has been smoldering and going on for some time. This was disturbing when Dr. Noble and I pulled these cases to evaluate them. Clinically the man looked as though he had an acute illness with fever and so forth. This is why I emphasize the only things we see in the heart in the way of an acute or even subacute inflammatory change are these few inflammatory cells in the epicardium.

DR. SOPER: There was no evidence of arteritis anywhere else in the body?

DR. BOLINGER: No.

DR. FISCH: Is this compatible with some of the lesions that Dr. Burch has described following viral myocarditis in which he demonstrated insufficiency of both mitral and aortic valves? He has a whole stable full of monkeys in whom he was able to produce viral valvular insufficiency. Can you say this is not an ordinary long-standing viral myocarditis?

DR. VELLIOS: This is the ash after the fire is out, and it could have been caused by any agent; but he does have changes typical of rheumatic changes of endocarditis involving the mitral and aortic valve. That we know, but what caused the enlarged heart with all these scars, I don't think there is any way of telling at this time.

DR. SOPER: Dr. Kleit, did you have any thoughts about whether dialysis might have been helpful in tiding this fellow over? If so, would you use hemodialysis or peritoneal, or do you have anything to add?

DR. STUART KLEIT: I think that the renal lesion that you see on the biopsy is something that's seen, as Heptinstall has pointed out, with rheumatic fever and in some patients with severe congestive heart failure. The kidney problem was predominantly prerenal, and we dialyzed this man very hesitantly on the basis that he probably was going to get into some trouble at that particular point from his kidneys, but really the way the dialysis went indicated that the whole problem was really with his heart and that his kidneys weren't contributing to this very much. For example, he was dialyzed for 12 hours and his BUN didn't move at all, and the exchanges were very well done and there were no problems there. The main problem was that the vasculature to his mesentery and his peritoneum was being affected just the same way his vasculature elsewhere was. To dialyze this man with an artificial kidney would be an impossible situation. I question whether I would

repeat this again faced with the same situation.

A PHYSICIAN: Was there damage to muscle or brain that could conceivably have played a part in the elevation of the CPK?

DR. BOLINGER: The brain was normal except for some edema of the meninges.

DR. FISCH: I think this boy had an acute illness starting three weeks ago. His CPK went up, his temperature went up to 102°, white count of 30,000, he had changing EKG's, he had nonparoxysmal nodal tachycardia, he had something acute at that time and it may have been added onto his underlying disease.

A PHYSICIAN: Was the voluntary muscle examined at the time of autopsy?

DR. BOLINGER: The skeletal muscle in the psoas area is what we routinely examine, and sections of that were normal. We didn't see anything wrong.

DR. SOPER: This is one of the reasons I raised the question about arteritis. I think that this certainly could have helped explain a lot of things, if they had found any evidence to support it.

Dr. Fisch, would you just say a word or two about whether you think people like this boy should be kept on prophylactic penicillin and what might have been done as far as treating him for bacterial endocarditis — whether you would have followed about the course that they did and started him on the program they did; and also about the problems they got into with the digitalis?

DR. FISCH: I would have treated him exactly the way he was treated. You have to assume he had an acute endocarditis from what was given here, particularly in the presence of a wide-open AI. As far as long-term prophylactic penicillin, we use this routinely in our patients. Nobody has decided how long to do it. We do it as long as they'll put up with it.

Digitalis toxicity may be a factor here, but I am more inclined to think the arrhythmia was from disease, especially as it is later described as a double arrhythmia; it is most likely related to his myocardial problem. We can't disregard the Q waves; we can't disregard the changes of the EKG from day to day. That indicates that there is a moving situation in the myocardium that was acute in nature.

DR. SOPER: I think that we all are acutely aware of the shortcomings that we have clinically in handling these people and that the study of the pathology at the time of autopsy leaves us sometimes hanging in the air. We cannot come to any definitive conclusion here. The problem has been nicely coned down by Dr. Fisch and the fact remains that nothing that we could do for this boy would have helped him to survive. ◄

in the treatment of
IMPOTENCE

Android®
(thyroid-androgen) TABLETS

*Effectiveness confirmed by another double blind study**

1. SUMMARY
ANDROID — GOOD TO EXCELLENT 75%
PLACEBO — 20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

*"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths

Android
Each yellow tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY
Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY
Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C
Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

Write for literature and samples:
BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

REFER TO PDR

also available with ESTROGEN
Android-E
Each Tablet Contains:
Methyl Testosterone ..... 2.5 mg.
Ethinyl Estradiol ..... 0.02 mg.
Thyroid Ext. (1/6 gr.) ..... 10 mg.
Thiamine Hydrochloride .... 10 mg.
Glutamic Acid ..... 50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE:** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS:** In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRA-INDICATIONS:** See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

X-RAY CONFERENCE

Bicornuate Uterus With Hypoplasia of Right Anglage

ERICH K. LANG, M.D.
Shreveport, La.*

THIS 24-year-old white female was admitted to Methodist Hospital. Indianapolis, for a sterility workup. The patient had been married for three years, gave a normal menstrual history, but had so far been unable to conceive.

Pelvic examination suggested the presence of a rather large uterus, tilted to the left, and retroflexed on bimanual examination. The examiner noted a nubbin-like mass projecting along the right lateral circumference of the uterus. The external cervical os appeared to be unremarkable. The vagina and external genitalia were normal. The temperature chart, maintained by the patient over the past six months, suggested a normal ovulatory cycle. Vaginal smears revealed normal glycogen content of the cells.

A hysterosalpingogram was performed, and demonstrated a uterine cavity tilted sharply to the left and retroflexed. The left tube filled readily from this uterine cavity. A small soft tissue shadow appeared to protrude to the right and form the right lateral margin of the uterine soft tissue shadow. Careful inspection of the cervical os demonstrated a second cervical canal, hypoplastic and diminutive in size, which appeared to communicate to a hypoplastic uterine cavity on the right side.

The diagnosis of a bifid uterus with complete subseptation extending into the cervix was, therefore, made. The fertility problem was related to the subseptation of the cervix, with compression of the cervical canal of the left cornu of the uterus by the hypoplastic right cornu (Figure 1).

Discussion

Hysterosalpingography is a useful tool for the assessment of intrauterine pathology, which may often be the cause of a fertility problem. After proper effacement of the cervical orifice seen between the blades of a speculum, an occluding tip obdurator is engaged into the external os of the cervical canal. Positive contrast material is injected in such an amount as to adequately delineate the uterine cavity. Filling defects in the uterine cavity may be secondary to submucous or intramuscular fibromyomata and are readily demonstrable by this method. The demon-

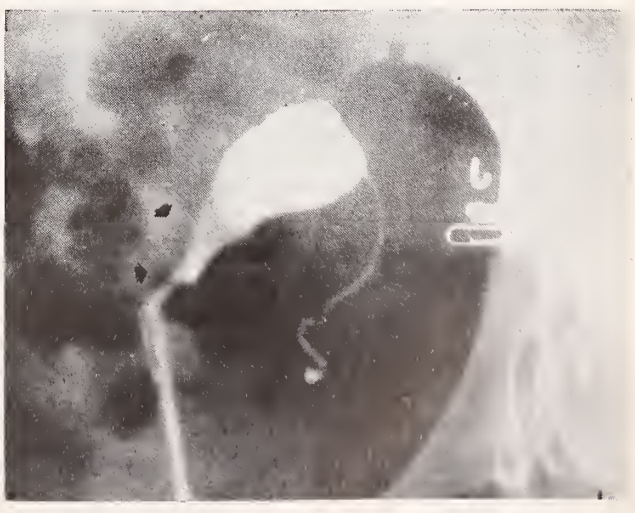


FIGURE 1

THE uterine cavity is readily delineated by contrast material (Salpinx). A sharp tilt of the cervical canal and uterine cavity to the left is demonstrated. Only the left tube fills. A soft tissue mass protrudes to the right of the lower segment of the uterus, and compresses the cervical canal. This represents a hypoplastic right uterine cornu, served by a separate cervical canal (arrows). Note the compression of the cervical canal due to the tilt and mass of the hypoplastic half of the uterus.

* From the Department of Radiology, Louisiana State University School of Medicine, Confederate Memorial Center, Shreveport 71106. Dr. Lang formerly was at Methodist Hospital, Indianapolis.

stration of both tubes is imperative for the assessment of patency of the tubes, and is a diagnostic sign that a single uterine cavity rather than a bicornuate uterus is injected and demonstrated. The absence of filling of a tube suggests either obliteration of the tube by inflammatory or neoplastic process, or a congenital anomaly such as a bicornuate uterus, with filling of only one-half of the uterine cavity. The method is extremely useful for the demonstration of a pyo- or hydrosalpinx. Conversely, free spillage of contrast material into the peritoneal cavity and coating of bowel loops on the delayed films proves patency of the tubes. ◄

As Others See It: Abusing Group Practice

Max H. Parrott, M.D., member American Medical Association Board of Trustees, before AMA's national Conference on Rural Health:

. . . Organizational entrapment can be brought about in two ways. One is the direct capture of a whole organization, by whatever means. The other is the more gradual process of individual entrapment within the organization. Then comes the process of bending the original purpose of the organization into a preconceived direction.

Our health care delivery system has become involved in this bureaucratic maneuvering. A specific example is the "medical group." Just about all of us practice in a grouping arrangement of some sort. Yet, we find the concept of group practice being deliberately subverted into a rigid organizational package, tied together with an attractive word like "prepayment." It's only a short step then to confine prepayment to a distinct group, which automatically creates the closed panel! Once accomplished, two other dominoes fall in line. The first is salaried physicians and the loss of the fee for service principle. The second is the loss of freedom of choice of physician.

Here we have witnessed the capture of a good concept, group practice, by devious means. The virtues of group practice in general are emphasized, while the vices of a particular type of group practice are carefully obscured. Thus the public is seduced into buying a product that is beyond the limits of its understanding and knowledge. The capture and entrapment is accomplished by the subterfuge of devious definition. It is then a very simple matter to eliminate, by omission, any competing system! . . .

I think it's high time that we take a cold, unimpassioned look at this "enforced trend" now being thrust upon us. Is prepaid, closed panel, group practice really the wave of the future? Is it the best system? Is it the most economical system? Will it meet all the needs of a diversified America? Or isn't it really a highly urbanized concept which cannot be applied to the rural, the suburban, or, for that matter, the industrial needs of this country? . . .

It will be said that flexibility and humanism can be built into these systems and perhaps it can, but such has not been the history of complex organizations. The direction is toward more rigid rather than more flexible standards and it follows that the more rigid the system, the less personal it becomes.

Senator Ribicoff of Connecticut, in a recent speech . . . , stated that we have no system of medical care at the present, but his statement doesn't make it so. If we have no system, we have come a long way on air pudding and wind sauce. He is one who would "enforce the trend" into another system. We have at present a flexible system of medical care. Where it is closely associated with organized medicine, with its service bureaus, grievance committees, insurance and business commissions and other services, it becomes a very good system. Not perfect, perhaps, but very good. And, it will not be improved by infusion of federal money and the rigid enforced trends that inevitably go along with "federal benevolence."

One move toward rigidity is the setting of "national standards." National licensure, national recertification, national education, national formularies, national procedural manuals, national do's and don'ts and warnings will never solve the problems as well as our present voluntary guidelines, the system of peer evaluation set up by our own medical organizations. Personal motivation is not a legislative matter. . . .

We have no quarrel with so-called group practice and its right to exist. We do have a quarrel with its existence to the exclusion of other systems, particularly when, in a relatively free market, it has been able to accumulate less than 15% of the service. We do have a quarrel when public funds are deliberately used to promote one system over the other.

In the games that people play, the name of the game is called control. The name of the game is called winning. The name of the game is called winning control. These enforced trends and organizational entrapments are a series of means to accomplish these ends. My plea is that we remain alert to these mechanisms during the planning and implementation of the socio-medical legislation of the 89th Congress. . . . *The AMA News*, May 20, 1968.

Let's be specific about Campbell's Soups...
and *reducing diets*

There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

burning
itching
discharge
of trichomonal vaginitis...

Flagyl®

tablets/inserts

brand of

metronidazole

brings

- clinical cures
- microscopic cures
- culture cures

For the most widespread form of vaginitis the most widely successful therapeutic agent, Flagyl, is clearly indicated.

In trichomonal vaginitis, most physicians have reported a cure-rate of 95 per cent or more with Flagyl when infected male partners are treated concurrently and when treatment is repeated for occasional refractory infections in women.

Among the few patients who do not respond to Flagyl are those who may not have taken the prescribed dosage and those who may have been reinfected.

This high rate of cure obtained with Flagyl is unparalleled. Only systemically active Flagyl reaches the hidden reservoirs of reinfection in male and female genitourinary tracts.

Indications: Flagyl is indicated only in the treatment of trichomoniasis in both the male and female.

Contraindications: Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution: Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side effects: Infrequent and minor side effects include nausea, metallic taste and furry tongue. Gastrointestinal disturbances, flushing and headache sometimes occur, especially with concomitant ingestion of alcohol. The taste of alcoholic beverages may be altered. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness or paresthesia of an extremity, joint pains, confusion, irritability, weakness, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

Dosage and Administration: In women: one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

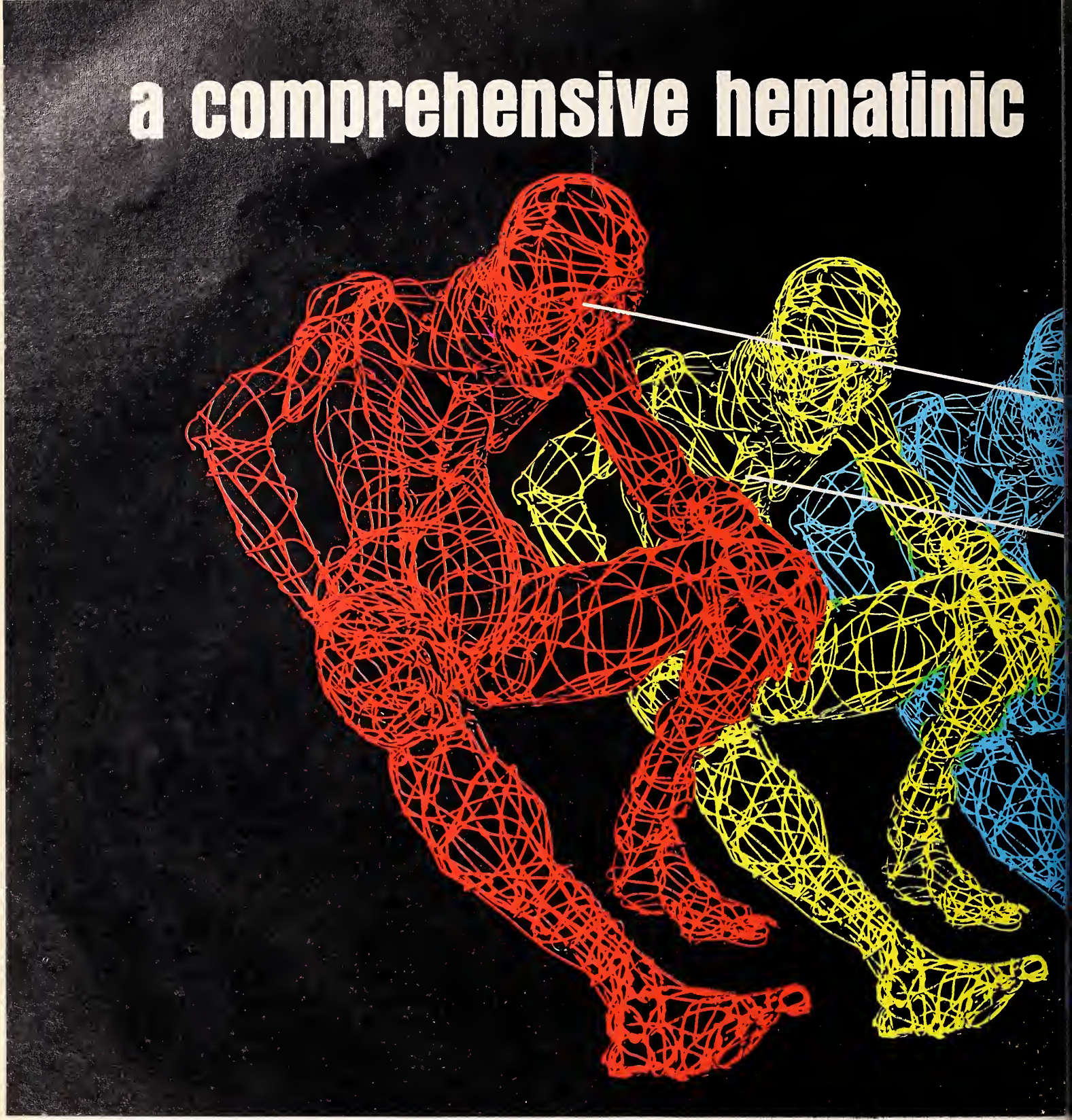
In men: When trichomonads are demonstrated, one 250-mg. oral tablet twice daily for ten days in conjunction with treatment of his female partner.

Dosage Forms: Oral tablets—250 mg.
Vaginal inserts—500 mg.

SEARLE

Research in the Service of Medicine

a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150	mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5	mcg.
Iron, Elemental (as Ferrous Fumarate)	110	mg.
Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

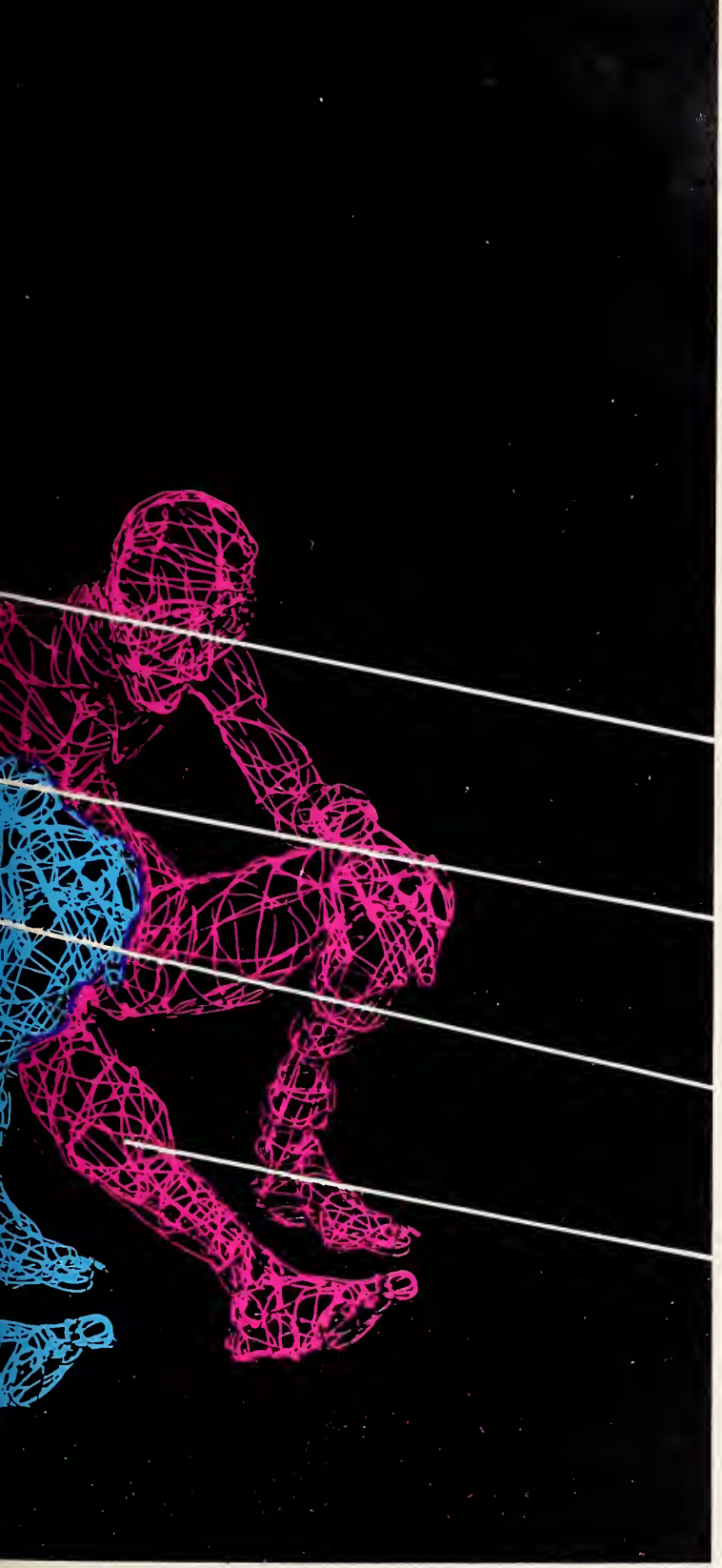
Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequate vitamin B_{12} therapy may result in hematologic remission but neurological progression. Adequate doses of vitamin B_{12} (parenteral, or oral with potent intrinsic factor as in Trinsicon® [hematinic concentrate with intrinsic factor, Lilly]) usually prevent, halt, or improve the neurological changes.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potentiation of absorption of physiological doses of vitamin B_{12}. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B_{12}, may be necessary. No single regimen fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Periodic



You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

- **Vitamin B_{12} plus intrinsic factor (15 mcg B_{12} activity)—helps provide adequate levels of this important vitamin.**
- **Folic acid (1 mg.)—treats nutritiona macrocytic anemias and/or malabsorp tion syndromes.**
- **Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active forn and helps iron absorption.**
- **Iron (110 mg.)—treats hypochromic anemia.**

clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500. [032566]

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206.

801668

Lilly

Tower of Babble

Are your patients confused by ad claims? by shapes and sizes? by strange-sounding ingredients? When they need fast relief from pain, you can reassure them that aspirin is still the strongest analgesic they can buy without your prescription. And Bayer is 100% aspirin. No wonder Bayer works wonders.

the antacid puzzle

In peptic ulcer:

solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

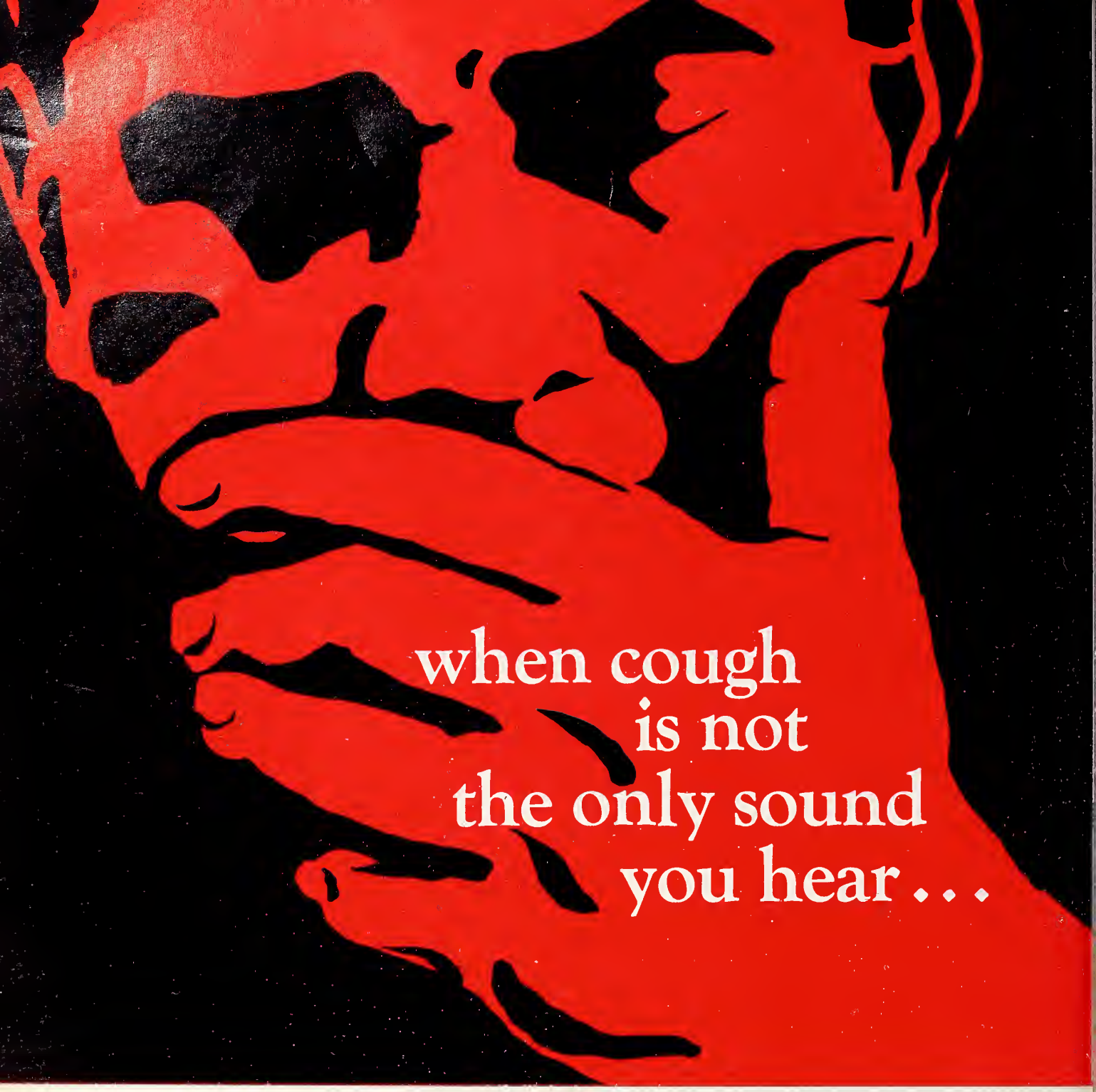
"will this one taste O.K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart

Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.



OMNI-TUSS® b.i.d.

. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

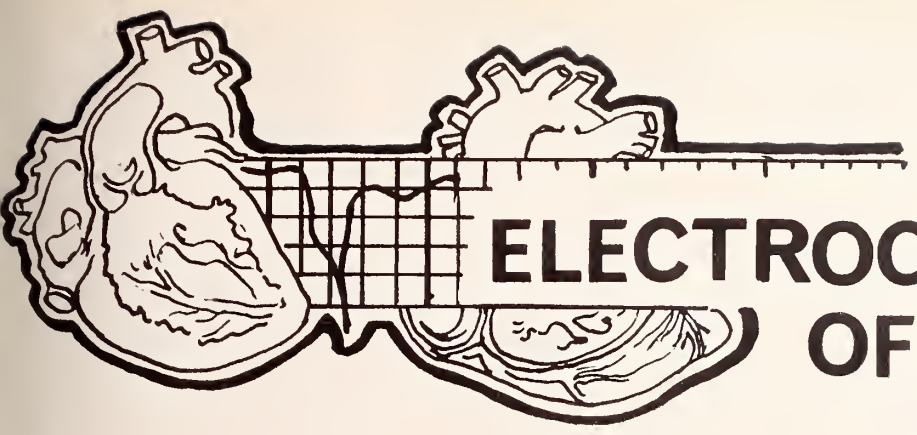
Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh
Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.



ELECTROCARDIOGRAM OF THE MONTH

CHARLES FISCH, M.D.
*Indianapolis**

THE next three "ECG of the Month" (July, August, September) will be devoted to stressing the nonspecificity of the electrocardiographic T wave. It has been pointed out repeatedly that T waves can be altered by a host of conditions including primary organic heart disease, organic systemic disease with normal beats, organic systemic disease secondarily involving the heart, drugs, electrolytes, acid-base balance, metabolic changes, physiological intervention and occasionally T waves may be "abnormal" in the absence of any of the above.

The accompanying figure is a composite of precordial leads of five different patients with T wave abnormalities. After you have jotted down your impression of the etiological diagnosis for each of the five cases, please turn the page upside down for the answer.

It is obvious that a specific diagnosis of T wave inversion is impossible from the ECG alone. It must take into account the entire clinical and laboratory picture.

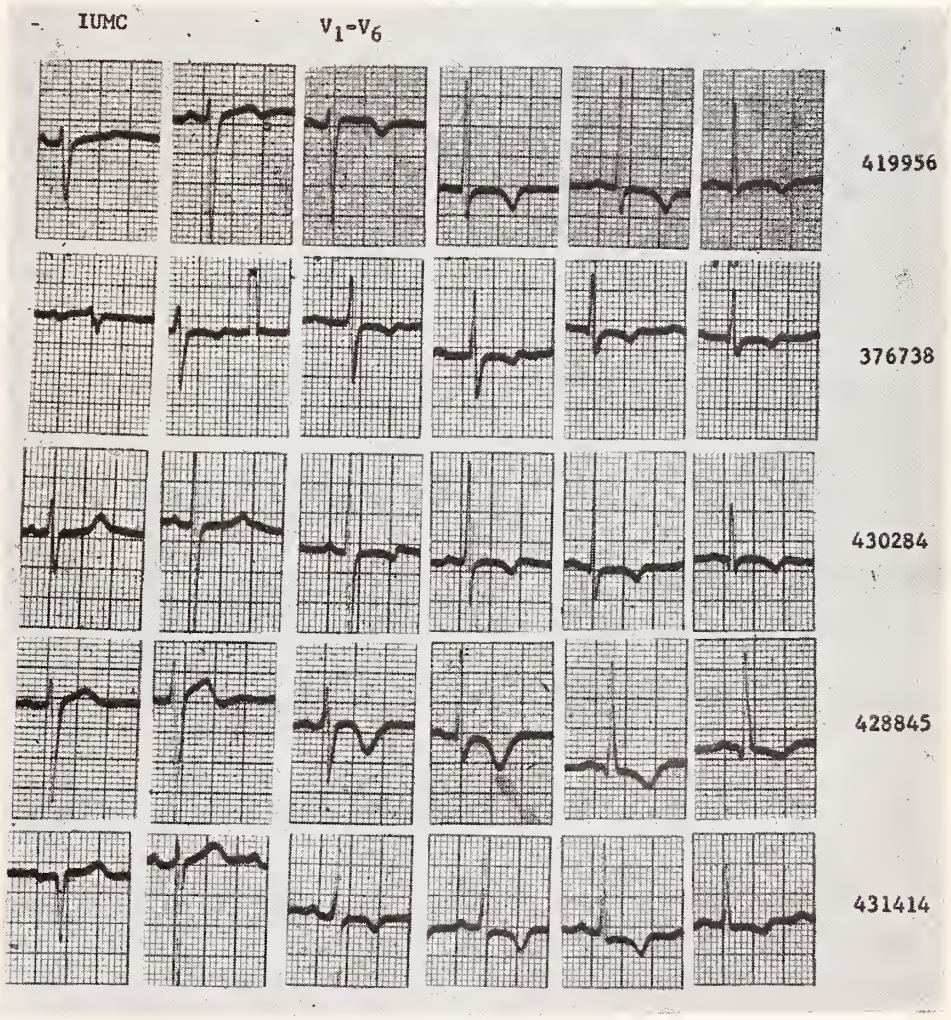
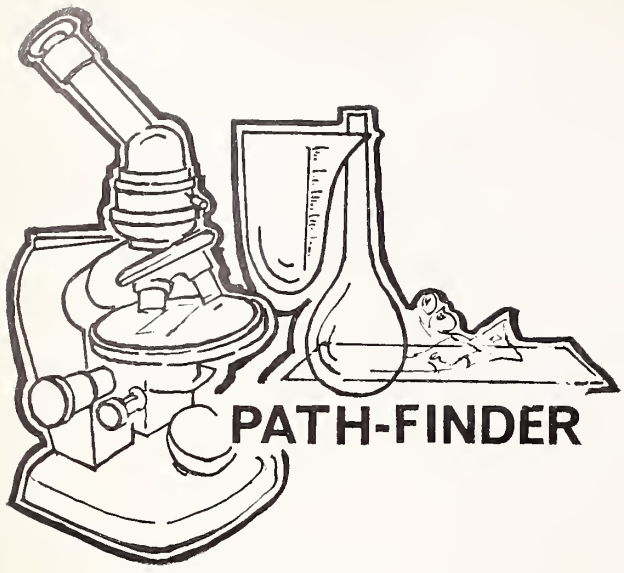


FIGURE 1

Case 419956 — Subaortic Stenosis
Case 376738 — Calcific (Non-constricting) Pericardium
Case 430284 — Acute Pericarditis
Case 428845 — Myocardial Infarction
Case 431414 — Hypertension

* Professor of Medicine; Director, Cardiovascular Division; Director, Krannert Institute of Cardiology, Marion County General Hospital, Indianapolis 46202.



This series is intended to emphasize the importance of judicious selection and proper interpretation of newer laboratory procedures as applied to differential diagnosis of various diseases. It is edited by Leon L. Blum, M.D., Terre Haute.

What's Your Diagnosis?[*]

History: A five-year-old boy was admitted to the hospital for removal of infected tonsils and adenoid tissue. His past history and family history were revealing as to bleeding tendency.

Laboratory findings: CBC, bleeding time, platelet count and prothrombin time were all within normal limits. Whole blood clotting time by capillary method was borderline or slightly prolonged.

Hospital course and additional laboratory findings: The boy showed profuse bleeding during and after surgery. A hematologist was called in for consultation. At that moment a PTT test (partial thromboplastin time) showed 180 seconds (normal: 45 to 75 seconds) and a TGT test (thromboplastin generation test) showed 20 seconds (normal: 8 to 12 seconds). The abnormal TGT was corrected by normal fresh plasma or adsorbed plasma. It was not corrected by normal serum. The bleeding tendency was finally corrected by transfusions of fresh blood.

Diagnosis: Classical hemophilia A (Factor VIII or AHG deficiency).

Discussion

The diagnosis was initially missed because of the uncertain bleeding history and the normal laboratory findings on admission. The clotting time by capillary method was only borderline abnormal and was not sensitive enough to indicate the Factor VIII deficiency. The abnormal PTT test performed later was a valuable indicator and the Factor VIII deficiency was then confirmed by the TGT test. This is a classical example indicating that PTT is much more valuable than the clotting time and should be routinely performed before surgery.

PTT measures plasma factor deficiencies (Factors V, VIII, IX, X, XI) and is easy to perform. TGT measures deficiency of Factors V, VIII. IX, X and platelet factor 3. It is much more complicated to perform and is generally used as a confirmatory test. In this case the abnormal TGT was corrected by normal fresh plasma or adsorbed plasma which contains Factor VIII, and not by normal serum which is deficient of Factor VIII. ◄

[*] Submitted by Wei-Ping Loh, M.D., chief pathologist and a certified hematologist at the Methodist Hospital of Gary. Inc., Gary and an associate professor of pathology at the Chicago Medical School.

Dear Doctor:

Wouldn't you like your patients to learn more about the contributions made by the world of medicine to their welfare? So that they can better appreciate the efforts of the health team to keep them in good health?

To tell the stories of medical and pharmaceutical advances to people throughout the country, the Pharmaceutical Manufacturers Association is sponsoring a unique "magazine within a magazine." It is called *Medicines and your family's health* and the first issue appears in the November *Reader's Digest*.

We would like to send you 50 free reprints of *Medicines and your family's health* for use in your reception room. Your patients will find the articles in this issue factual, educational and of immediate personal interest.

Just fill out the coupon below and send it to us.

Order Desk
Pharmaceutical Manufacturers Association
1155 Fifteenth St., N.W.
Washington, D. C. 20005

Gentlemen:
Please send me 50 free copies of
Medicines and your family's health.

Name_____

Street_____

City_____ State_____ Zip_____

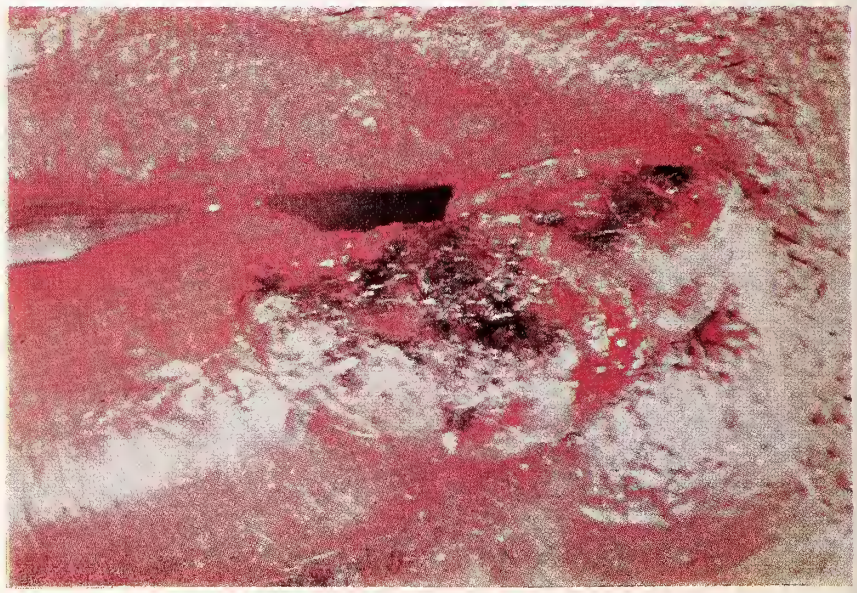
The Cancer You View

Edited by

Edwin E. Pontius, M.D.

Indianapolis

JOHN G. PANTZER, M.D.
Indianapolis*



A 58-year-old white man went to his physician with a firm, elevated and ulcerated lesion of the left lower lip. A farmer by occupation, he stated that dryness and cracking of his lips had been a problem for a long time. He first noted changes in this area approximately one year ago but had not experienced any pain as the lesion enlarged. Examination revealed no palpable adenopathy. The patient was otherwise enjoying good health.

What is your diagnosis?

How would you confirm this?

What is your treatment plan?

For diagnosis and discussion please see page 1057.

* Instructor in Plastic Surgery, Indiana University School of Medicine, Indianapolis 46202.

Supported in part by a grant from the American Cancer Society, Indiana Division, Inc.

Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL PEN•VEE® K

(potassium phenoxymethyl penicillin) Wyeth

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 1802 North Illinois Street, Indianapolis, Ind. 46202.

Associate Editors: A. W. Cavins, M.D., 221 South Sixth Street, Terre Haute; Lall G. Montgomery, M.D., Ball Memorial Hospital, Muncie; David A. Bickel, M.D., 515 Odd Fellows Building, South Bend, Samuel R. Mercer, M.D., 702 Medical Center Bldg., Fort Wayne; I. W. Wilkens, M.D., 1743 Shelby St., Indianapolis.

Editorial Board:	Term Expires
Alvin J. Haley, M.D., Fort Wayne	Dec. 31, 1968
Wei-Ping Loh, M.D., Gary	Dec. 31, 1968
Jack W. Hickman, M.D., Indianapolis	Dec. 31, 1969
Frank H. Coble, M.D., Richmond	Dec. 31, 1969
Jene R. Bennett, M.D., South Bend	Dec. 31, 1970
W. D. Snively, Jr., M.D., Evansville	Dec. 31, 1970

Assistant Editor: Jackie Freers Stahl
Business Manager: James A. Waggener
3935 N. Meridian, Indianapolis, Indiana 46208.

Pharmaceutical Industry Research

THE goal of the pharmaceutical industry to assist in the provision of high quality medical care at a reasonable cost was highlighted recently by Mr. Joseph Stetler, President of the Pharmaceutical Manufacturers Association. The occasion was the release of President Johnson's special health message to Congress.

Mr. Stetler pointed out that the drug industry this year will reach the half-billion dollar mark in annual research expenditures—all devoted to the search for and the improvement of new pharmaceutical products.

He pledged the assistance of the pharmaceutical manufacturers in the national effort to modify the high cost of modern health care which in 1966 increased by 6.6%. One of the factors, he said, which is modifying the escalation of medical care expense is the cost of prescription drugs which has declined 10% on the Bureau of Labor Statistics Index in less than 10 years.

The decline in drug prices in recent years is illustrated also by the fact that prescription drugs take only 9.8 cents of the health care dollar as compared with 11.7 cents in 1957.

Mr. Stetler emphasized that the pharmaceutical industry is in full accord with the President's effort to cut medical costs, if possible, in federal programs. He noted that many firms, through rebates on welfare prescriptions and through lower prices on large-scale purchases by local, state and federal agencies, have already helped to bring about substantial savings.

He also said that "We do have a concern that price alone not be the only consideration in the prescribing, dispensing or purchase of prescription drugs. Quality, too, must be maintained so that recipients do not become second-class medical citizens. This is the real danger if the myth of the generic equivalency of drugs prevails."

The experience of the Defense Supply Agency bears out the fact that generic equivalency is a fable, Mr. Stetler stated, and added that the manufacturer source should always be identified and that the physician should have the freedom to prescribe as he deems best for his patient. Certainly he should take price as well as quality into consideration.

Indiana School and Community Health Workshop

THE Indiana School and Community Health Workshop, oldest of its kind and a prototype for similar conferences in many other states, will conduct its 25th annual meeting from August 9 to 23.

It is sponsored by Indiana University, the Indiana State Board of Health and the Indiana State Department of Public Instruction, with the assistance of the Indiana State Medical Association and the Indiana Dental Association, among many others.

Approximately 5,000 persons have attended during the quarter of a century and some 275 to 300 are expected to enroll this summer. Usually the participants represent 15 to 20 different states and several countries.

The workshop's programs have interested and provided educational experiences to teachers, school administrators, physicians, nurses, social workers and parents. The programs are devoted to discussion of the problems in providing the health needs of schools and communities. It is indeed a spontaneous, cooperative and voluntary develop-

ment over a long period of time which has goals in common with the recent Comprehensive Health Planning program initiated by federal law.

Eighteen health and welfare agencies assist in the planning and cooperate in providing personnel for the programs. The Indiana State Health Commissioner, the State Superintendent of Public Instruction, representatives of medical and dental associations and societies, PTA officers and members of many health agencies have all contributed in the past to the outstanding record of advancement and education which the workshop has achieved.

The workshop has not only rewarded its audiences with the highest type of advice and pioneering spirit in the field of community health, but has also periodically investigated its own aims and standards of usefulness. A survey about ten years ago made of the past participants to determine the value of the effort showed that 80% of those who replied considered the workshop to be a superior educational experience.

Past programs have included in-depth study of public health organizations, communicable disease control, local health services, environmental problems, health instruction, family life, mental health, handicaps, problems of the aged and the use of drugs and alcohol. All this with special emphasis on the importance of good working relationships among community agencies and the need for coordination of program efforts.

The physicians of Indiana may well be proud of their association with such a magnificent program in community health. The workshop and its findings and teachings should stand us in good stead while we are participating in the new-fangled Comprehensive Health Planning.

Guest Editorial

Plastic Surgery: Reconstructive or Cosmetic?

To differentiate between cosmetic and reconstructive surgery would be academic were it not for third party interposition. Today, however, all but a few patients referred to a surgeon have health insurance that covers, fully or in part, professional fees for surgical services. In many instances contract terms exclude "cosmetic surgery," and often surgical procedures are arbitrarily placed in this classification without appreciation of the distinction between cosmetic and reconstructive surgery.

Dorland's medical dictionary defines *cosmesis* as "the art of increasing or preserving beauty." *Cosmetic* is explained as "beautifying; tending to preserve or restore comeliness." Other references offer similar definitions. In common parlance *cosmetics* refers to various creams, lotions, sprays, powders, etc., which women use to enhance beauty by providing color, accentuating facial features or camouflaging minor blemishes. These interpretations support the opinion that the term "cosmetic" as applied to surgery should be replaced, perhaps by "esthetic," a more accurate and more descriptive adjective.

In their two-volume work, *The Principles and Art of Plastic Surgery*, the late Sir Harold Gillies and D. Ralph Millard have written a chapter entitled "Reduction and Aesthetic Surgery." Allowing considerable latitude for interpretation, these authors distinguish thus between cosmetic and reconstructive surgery: "Reconstructive surgery is an attempt to return to normal; cosmetic surgery is an attempt to surpass the normal." This is a fairly accurate definition, except for the verb "to return" which might, strictly interpreted, eliminate congenital defects from the reconstructive classification.

Which operative procedures in plastic surgery are cosmetic or esthetic and which are reconstructive? The answer cannot be based on any single criterion such as "the improvement of appearance," for then procedures such as cheiloplasty for the incomplete cleft lip and removal of facial birthmarks might be classified as "cosmetic." Neither etiology nor motivation can always be the sole basis for differentiation. Rather a combination of criteria should be used. Definite categorization of surgical procedures would be helpful in many instances, but certain procedures are cosmetic in one instance and reconstructive in the next.

Rhinoplasty—an operation to change the size and/or contour of the nose—falls into the cosmetic category when there is no disturbance of airway function and when the nose is considered to fall within acceptable limits of appearance. On the other hand, if one or both nasal passages is compromised, if there is clear-cut evidence of previous nasal injury, or if the contour and/or size of the nose is such that it is significantly disproportionate to the rest of the face, then rhinoplasty should be considered reconstructive.

A young child with ears that protrude significantly from the side of the head is a candidate for reconstructive otoplasty in order to avoid the taunting of playmates and the development of an irreversible self-conscious attitude because of ear prominence. On the other hand, an adult with minimal protrusion of the ears who wishes to have an otoplasty performed will usually accept this procedure as being cosmetic in nature.

Mammoplasty—alteration in the size and contour of the breasts—is another procedure that in some instances can be classified as reconstructive and in others as cosmetic. The patient with large, ptotic breasts

often has physical symptoms of such magnitude that reduction mammoplasty is a procedure that is partially ablative and partially reconstructive. Augmentation mammoplasty, usually involving the insertion of subcutaneous prostheses, is a cosmetic operation that is performed for the sole reason of increasing breast size in the woman who has normal, but relatively small, breasts. On the other hand, the patient who undergoes complete subcutaneous mastectomy for chronic intractable cystic mastitis with immediate prosthetic replacement is not undergoing cosmetic surgery. The insertion of prostheses in this instance is a part of the reconstructive phase of surgery following total breast tissue ablation.

Abdominal lipectomy—reduction of anterior abdominal wall redundancy—is cosmetic if the deformity is minimal to moderate, unaccompanied by an umbilical hernia and commensurate with the age and physical stature of the individual. On the other hand, when the markedly overweight patient reduces significantly and a large abdominal apron is the residual, surgical removal of this excess tissue should be considered both ablative and reconstructive.

In the instances cited above, we consider, among other factors, the age of the patient, the etiology of the deformity and the presence or absence of physical symptoms in determining the nature of a given operative procedure. As stated earlier, it may take a combination of these and other criteria in arriving at the final determination.

In the last analysis the decision as to whether a surgical procedure is cosmetic or reconstructive should depend on the judgment and intellectual honesty of the surgeon—attributes often ignored by third party groups. Many procedures in plastic surgery, although designed primarily to restore acceptable appearance, are uniformly recognized as being reconstructive in nature. Where any element of functional restoration is present or anticipated, the procedure is considered reparative or reconstructive rather than cosmetic. The surgeon, of course, must be careful not to stretch a point with regard to function in order to obtain authorization or patient reimbursement. The idea, of course, is that stretching a point should be unnecessary if the procedure is other than cosmetic.—**James E. Bennett, M.D., Professor of Surgery and Director, Plastic Surgery Section, Indiana University School of Medicine, Indianapolis 46202.**

Editorial Notes . . .

National Merit Scholarship Semifinalists in 1966 indicated medicine as their choice of career a little more than twice as frequently as did representative college freshmen. Semifinalists in the National Merit Scholarship program represent the top one percent of all students graduating from high schools in the U.S. The National Merit group elected medicine in 7.8% of instances in contrast to the 3.4% choice by college freshmen.

Ben Z. Tabor, M.D., medical director of Syntex Laboratories, disagrees both with the theory that oral contraceptives interfere with subsequent fertility and with the view that they enhance fertility. He likens the period after cessation of contraceptive medication to the postpartum interval between delivery and return of fertility. "The majority of couples will be successful within six to 12 months."

Drug stores without "variety" merchandise are being established in the Chicago area. Nationwide Pharmacy Centers expects to open 12 centers this year. Each will handle a full line of pharmaceuticals, both prescription and over-the-counter, and will sell and rent durable medical goods for use in the sick room and by convalescents. No toasters, momma dolls or garden hoses.

BioSciences Information Service (BIOSIS) will make available to subscribers to the printed edition of *Biological Abstracts* its microfilm digest of 2,000,000 research references. The film is composed of abstracts of bioresearch papers published in 109 magazines since 1927 and contains the bulk of important discoveries in life science research.

Thyrocalcitonin, the calcium regulating hormone which is secreted by the thyroid gland, can now be made synthetically. Scientists of the National Institutes of Health have demonstrated that the hormone is a 32-amino-acid peptide and have also discovered the order in which the amino acids are arranged. Two methods were used to determine the sequence and when the results were found to be identical, the work of artificial synthesis began. Armour Pharmaceutical Laboratories supplied the partially purified thyroid extract necessary for the basic research. Sandoz, Ltd., of Switzerland, makes the hormone. Ciba and Lederle Laboratories have also been successful.

High-rise buildings compound fire fighting problems so much that the National Fire Protection Association is recommending that all high buildings, even though of fire-resistant construction, should have complete automatic sprinkler systems because of the great number of men required for fire fighting in high structures. Fire resistive construction resists fire but does produce smoke and toxic gases. Automatic sprinklers provide the added control factor which makes the fire department's work much more effective. ◄

I've turned my
delinquent accounts
over to the professionals

Good idea! Now there's plenty of time to try for that hole-in-one, or relax anyway he wishes. No more time consuming, time wasting efforts at personally attempting to collect those past due accounts.

Our skilled collectors will do the work and take the worry off your hands. This is their field of specialization; real experts who will protect the intimate doctor-patient relationship while recovering lost money, cutting credit losses and rehabilitating accounts.

Get that "right down the middle" feeling.

Call us today!

Associated Credit Bureaus

OF INDIANA

affiliated with

ASSOCIATED CREDIT BUREAUS OF AMERICA

Contact your local ASSOCIATED CREDIT BUREAU OF INDIANA *member*

President's Page

Through all the years of its history, the state of Indiana has been blessed by a multitude of faithful public servants — some of whom achieved prominence, many of whom were known only in their own sphere of work, but all of whom have contributed immensely to their profession and to the best interests of our communities, our state and our nation.

It is with a deep sense of pride that I take this opportunity to honor one of our own members — Lester D. Bibler, M.D., who has just completed six years of service as a member of the Board of Trustees of the AMA, the last year of which he was chairman of the Executive Committee of that body. Lester has always represented the interests of Indiana and of the medical profession. He has done so in his own quiet, self-effacing and modest manner.

May I present his curriculum vitae which will give some small idea of the service our colleague has rendered to our profession and to the people of our state and nation.

Born in Findlay, Ohio on January 13, 1902. Graduate of Muncie High School in Indiana — 1919; B.S., Indiana University — 1923; Indiana University School of Medicine — 1925; Internship Methodist Hospital, Indianapolis, Indiana — 1925, 1926; Active general practice, Indiana 1926 to date.

Offices: Delegate of the Section of General Practice of the American Medical Association; Chairman of the Medical Practice Committee of the American Medical Association; Vice-President of the American Academy of General Practice; Chairman of the Section of General Practice of the American Medical Association 1951-1952; Chairman of the Section of General Practice of the Indiana State Medical Association; President of the Indiana Academy of General Practice; President of the Indianapolis Mercator Club; District Councilor of the Indiana State Medical Association, 1953-56; Officer of the U. S. Navy 1940-46; Councilor of Indiana University Alumni Association; President of the Mercator Clubs of America; Commanding Officer of Medical Unit 9-3, MC-USNR; President of Torch Club of Indianapolis.

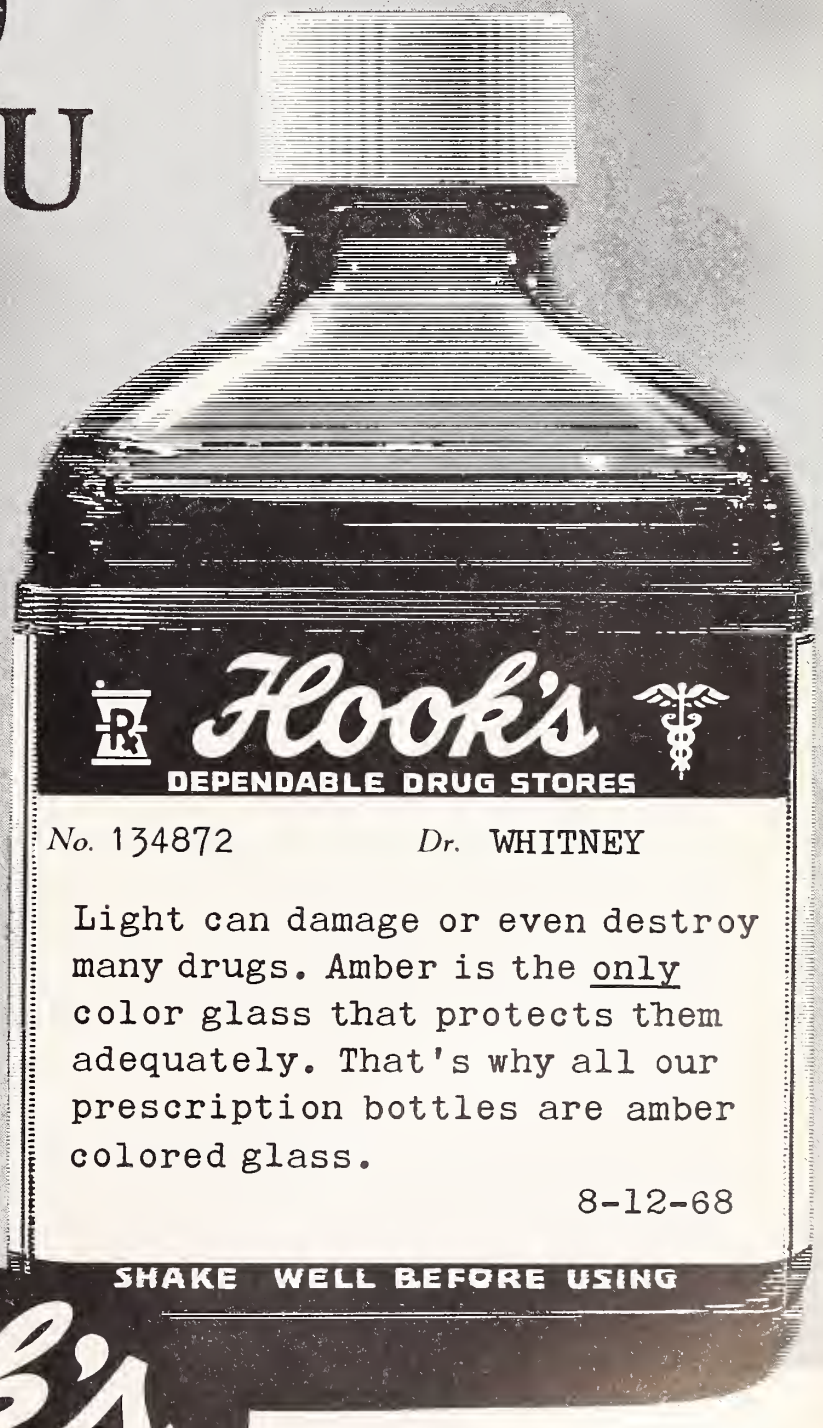
Offices: Trustee of the American Medical Association; Member of the Executive Committee of the Board of Trustees of the American Medical Association; Member of American Academy of General Practice; Indiana Academy of General Practice; Indiana State Medical Association; Chairman of Student Loan Fund; Marion County Medical Society; Member of the Active Staff of Methodist Hospital, Community Hospital, Winona Hospital and Indiana University Hospital, Indianapolis, Indiana; Trustee of the Indiana Alumni Association of Phi Beta Pi; Committee on Education of the Indianapolis Chamber of Commerce; State Sous Director of Nurses Training of 40 & 8; Member of the Advisory Committee of Central State Hospital; Professional member of the Board of Directors of the American Cancer Society, Indiana Division; member of the National Rehabilitation Advisory Board of the American Legion.

Member of the Northwood Christian Church, Masons, Scottish Rite, Murat Shrine, Jesters, Chamber of Commerce, Paul Coble Post #26 of the American Legion, Member of Phi Beta Pi Medical Alumni Association, Torch Club.

As President of the ISMA, I salute you. We need more like you. May your opportunities for future service be still greater.

G. O. Larson M.D.

What's Good for Your PRESCRIPTION is GOOD FOR YOU



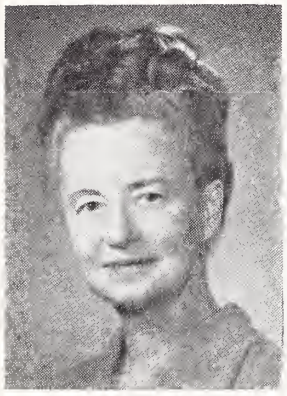
Hook's
DEPENDABLE DRUG STORES

Hook's extra care and low prices may account for the ever growing number of our prescription customers. We believe so! We were trusted over 2½ million times last year; we invite you to compare and save.

The Woman's Auxiliary

REPORTS TO ISMA

The WA-ISMA Workshop held recently in Indianapolis was a most important planning session for the programs of the individual counties for this coming year. Interest in the field of Health Careers recruiting was high. Miss Jan Davidson of Indiana Health Careers, Inc., spoke at the morning session to spark interest and action among the auxiliary members for this fertile field of inquiry and accomplishment.



The Public Health Service and the American Hospital Association conducted a survey recently and found that the nation's hospitals need 275,000 additional professional and technical health workers, including 80,000 more professional health nurses and 40,000 more practical nurses. In other fields, general hospitals need 50,000 more medical aides and psychiatric institutions need 30,000. Over 9,000 more medical technologists and almost 7,000 more social workers are required as well as physical therapists, x-ray technologists and surgical technicians.

By 1970, health service will be the nation's largest industry and health manpower needs will be double the current number of health service workers now in the field. There are more than 71 *broad areas of occupational activity and over 700 health career opportunities on the health team.* Nearly six percent of the gross national product goes for health services—approximately $40 billion a year.

It is clear we must seriously and diligently work to recruit more personnel. Federal, state and local authorities are trying to promote programs to increase the numbers going into health fields to meet the nation's mounting needs. National associations such as the AMA, American Hospital Association and others are working together to help solve the problems found in recruiting and training. Coordinated efforts of all groups involved will stimulate health careers clubs, health careers workshops for student counselors, state health careers councils, "on the job" training programs, loan and scholarship programs—all essential spokes in the health careers wheel.

The woman's auxiliary (to the county medical society, state medical society and American Medical Association) offers many opportunities for the doctor's wife to serve on the health careers team in ways that are unique, vital and interesting. It is her opportunity to share with her doctor-husband the thrill of encouraging others to be "people caring for people." "The need for people who care has never been greater."

Betty Kephart

Your Contributions Are Needed . . .

SUPPORT THESE PROGRAMS OF THE AMA-ERF

- *Funds for Medical Schools* -- Contributions may be designated for one particular school. Undesignated contributions will be distributed equally among all medical schools. No restrictions are placed on the use made of this money by the schools.
- *Loan Guarantee Fund* -- Provides guaranteed loans to medical students, interns and residents. For every dollar in the fund, the private banking industry loans $12.50, at a maximum rate of 6% simple interest.
- *Honors and Scholarship Program* -- Designed to attract students of high promise to careers in medicine—meetings, personal contacts and written materials will be employed. Medical school scholarships will be available to those who need them.
- *Undesignated Contributions* -- Money not designated for any specific AMA-ERF program will be placed in the general fund and the Board of Directors will decide on its use, depending upon need.

AMA-ERF

American Medical Association
Education and Research Foundation
535 North Dearborn Street
Chicago 10, Illinois

"We Should Get Back to the Two-Party System—or—You Can't Have a Third Party Until You Have Two Parties."

The Sophist Society

ARTHUR G. BLAZEY, M.D.
Washington

DOCTORS aren't the only taxpayers who seem to have ignored the fiscal irresponsibility of our government for the past 35 years. Too many of our profession do not take the time to first investigate and then object to the wanton waste of taxes collected.

After the Constitutional Convention that gave us a memorable document to preserve life, liberty and property, a woman asked Benjamin Franklin "What kind of government have you given us?" He replied. "A Republic—if you can keep it." He well knew how apathy on the part of the governed had, in the history of previous governments, led to their destruction.

Less than 200 years have passed since Franklin's words of wisdom, and we are now faced with increasing inflation and impending bankruptcy because most members of Congress have ignored our founding Charter by passing laws that saddle American taxpayers with illegal interest charges. the cost of foreign aid and the ever increasing cost of supporting bums on the growing welfare rolls.

Doctors come in contact with almost as many people each day as could be contacted by a first class TV program. They have, in addition to treating patients, the opportunity to divulge some truths that might prevent the impending insolvency of this Republic. Yet, after more than half a century of calculated plunder of the U.S. Treasury by laws that are more swindling than the Ponzi scheme, less than 25% of the doctors of this nation are concerned about this erosion of our national heritage.

Medical Economics has been a widely read journal. It has, over the years, brought forth thousands of extremely valuable articles to inform doctors about economic problems. As an avid reader of almost every issue for the past 20 years, I do not recall, and I find no reference in my files, to any article that warned readers about the dangers of excessive taxation and deficit financing by a government that has now asked for a budget of 186 billion dollars to finance legitimate government plus foreign and domestic boondoggles.

Medical Economics did run a condensation of Stern's book entitled "The Great Treasury Raid" in 1955. That excellent digest of the book told how many of the big operators were getting away without paying income taxes. What the big boys got away with was merely added to the tax load of the little fellow.

"Too Damn Dumb"

This brings to mind a pertinent comment of Harry Hopkins. That's the era when Franklin Roosevelt took us off the gold standard and started the give-away programs that have increased to this day. FDR began to worry about the taxpayers objecting to the load he was placing on their backs. Hopkins replied, "Don't worry about that. Franklin, the American people are to damn dumb to object." Sure looks like he knew what he was talking about, doesn't it?

In 1946, I returned from World War II, not only to the private practice of medicine, but also to a study of how our government was operating. The picture looked bad. Socialized medicine almost went into effect via the Wagner-Murray-Dingle Bill. The fraud of Social Security was being naively accepted by more and more people. Federal intrusion into states rights was growing by leaps and bounds. In 1953 the AMA gave its sanction to the formation of the Department of Health. Education and Welfare. In 1954 the Supreme Court switched the limitations of the Constitution it swore to uphold to enact a "Civil Rights Law" based on the socialistic claptrap of Gunnar Myrdal who was imported by the Carnegie Corporation in 1938 to do a hatchet job on our government.

Yes, the picture looked bleak—but one must start somewhere. I was asked by a Republican Solon in a city near mine to run for state senator. I accepted on the basis that my platform would be: return to Constitutional government. That was in the 1954 primary elections. After several weeks of campaigning

wherein I learned that most of the Republican committeemen were no more interested in my platform than were their Democrat counterparts—or the bulk of workers for both parties. I began to wonder what difference there was between the two parties. About a week before election a local woman called to ask me if it was true that I was not in favor of Social Security. I told her that was my position. The result was no surprise to me. The incumbent Republican senator won the primary and lost to the Democrat from the Solon's city. Not many years later he became Governor of Indiana. I now feel that I was used as a political pawn whereby a Republican engineered the election of a Democrat. If you think that's a far fetched idea, your study of party politics needs attention. Everett Dirksen is one of LBJ's pals.

A Third Party

Well, so what! If both parties were going in the same direction, and there was no real choice for the voters—why not develop a party that would? After attending the States Rights Convention in Memphis in 1956 and meeting hundreds of people who had experiences similar to mine, I returned to Indiana for a meeting in Indianapolis where we started the Constitution Party of Indiana.

We had three months to obtain 8,000 notarized eligible voter signatures to put us on the ballot. With the help of For America, directed by General Bonner Fellers, and co-chaired by Dean Clarence Manion and Dan Smoot, we almost made the grade. We lacked a few hundred signatures by the September 1st deadline. We came so close that a "hatchet man" was in our state the following year to disrupt our organization. The same pattern of action has been used in other states since then, to stop the formation of, not a third party, but a genuine second party.

In 1957 the Indiana Legislature passed a withholding tax law. The Constitution Party instigated an injunction suit against the measure and filed the plea in an Indianapolis court where it was denied on the basis that Indiana had been collecting gasoline taxes for several years. Our appeal went to the Indiana Supreme Court which upheld the decision of the lower court. In essence, the courts said—so long as a precedent had been established, they did not have to be governed by the Constitution in their decisions.

If you can't buck the one-party political machine, and you can't get courts to render decisions based upon the Constitution—what other recourse does one have to stop the destruction of a Republic? About the only peaceful means left was to cut their supply of money. I first proposed that method at a meeting in Houston, Texas in 1962. I have no way of knowing how many of the several hundred people at that meeting used the idea.

"Victims" of IRS

Senator Long, who heads a committee investigating dubious tactics of various federal agencies, announced on a UPI press release dated 2-13-68, that many Americans are the "victims" of IRS agents who must catch a certain number of tax offenders to meet a quota system that is "officially" banned. Long said, "one of the reasons the IRS agents are willing to break state and federal laws is because of the quotas and production goals they have to meet."

While some citizens are worrying the IRS by cutting down on their work to curtail the extent of some of the asinine tax wastes we have only briefly discussed, there are other persons who have stated their objections on the Form 1040, signed their names and sent no money. Austin Flett of Chicago was one of the first to do this in 1958, the last time he paid any income tax. For ten years he has been demanding an indictment and a jury trial for him to be able to expose the violations of laws by the IRS. He says he won't pay any more income tax until he has his day in court. Only this year will he get that opportunity.

A. J. Porth of Wichita, Kansas is a runner-up. He has not paid the IRS since 1961. He lists the laws that are being violated on the first page of his 1040, signs it and sends it on with no check. He was indicted last year, tried and sentenced in a district federal court, and is now appealing his case. Then there is at least one doctor of medicine who is known to have taken the same course after learning how the people of this land are being fleeced by the IRS to further a Communist state in the USA, and to support Commy causes all over the globe. His name is William Campbell Douglas of Sarasota, Florida. He too has been indicted. He has not paid the IRS since 1964.

Summary

This narration can now be wrapped up with a few closing observations. Our executives, our Congress and our courts have been repudiating the foundation upon which this Republic was built and upon which it offered so much to so many until the termites of fiduciary felonists started their destruction of the beautiful building that stood on that firm foundation for so long. Honest leaders are needed who have courage and willingness to sacrifice their lives, their liberty and their sacred honor to destroy these termites and to repair the fiscal damage they have done so that our children may continue to enjoy the one nation under God with liberty and justice for all. Our profession was well represented among the signers of the Declaration of Independence. Let us be equally well represented in the crisis we now face. ◄

7 E. Walnut St.
Washington 47501

DAY BY DAY WITH THE F.D.A.

New York state has adopted stricter rules in regard to the sale of drugs in open containers. Now such drugs may be purchased only by pharmacy registrants for prompt removal to a pharmacy. Previously open containers of potent drugs were purchased by liquidators or auctioneers who stored them in a warehouse for resale. Lots of drugs were often mixed and insufficient regard was had for lot control numbers and expiration dates.

* * *

Some eight tons of butter, valued at $11,000, was seized in Los Angeles due to the finding of pesticide residues. The butter originated in Arizona where dairy feeds are known to contain plant materials bearing residues of DDT and related pesticides.

* * *

Meprobamate tablets were seized in several locations in Arizona and California after the medication was shown to have been manufactured from bulk powder to resemble meprobamate tablets made by a New Jersey firm. The labels imitated those of the New Jersey firm, even to typeface, and an actual control number. Ballistic comparisons showed that the tablets had not been made in New Jersey. The man from whom the tablets were confiscated in California said he had obtained them in the parking lot of the Hollywood Race Track.

An oven cleaner containing propane has been voluntarily recalled by its maker. "Aeroseal Super Foam Oven Cleaner" was said to have resulted in a severe explosion when sprayed into an oven. It cleaned out the oven all right, and possibly the whole kitchen too. Housewives reported severe burns from its use. FDA is checking all aerosol oven cleaners.

* * *

Labels got mixed up on castor oil bottles in California. Some two-ounce bottles labeled "Vi-John Hospital Brand Castor Oil" were found to contain turpentine. Two ounces of turpentine is enough to turn off your lights. The California Department of Public Health and the FDA issued a press release to warn all potential consumers. The company recalled all bottles.

* * *

Three hundred thousand dosage units of amphetamines and barbiturates and 130 pounds of barbiturate powder worth about a quarter of a million on the illicit market was seized in New York state. An undercover agent learned that the drugs had been stolen from a Long Island chemical company. The information facilitated the recovery of the loot intact and before it could be peddled.

* * *

Fifty thousand pounds of potatoes were destroyed in Oregon because they had been inadvertently packed in bags which had contained treated seed. Analyses confirmed mercury residues.

* * *

The Bureau of Drug Abuse Control reports the filing of charges against numerous drug stores, pharmacies and individuals all over the United States for illegal sales, no initial inventory and inadequate records pertaining to drugs controlled by the Drug Abuse Control Amendments of 1965. Thousands, hundreds of thousands and in some instances millions of dosage units are involved.

* * *

The occurrence of *Salmonella* in foods and the incidence of such infestations in humans remains at an inordinately high level despite much preventive work. Usually the foods involved are of animal origin—poultry, eggs and egg products, milk and meat products—and even thyroid, pancreatin and other drugs of animal origin. The reservoir of the infection is thought to be animal feed such as tankage, meat scrap meal and fish meal, which have not been heated enough to destroy the contaminant. Better control of animal feeds, both domestic and imported, is being sought.

* * *

A promoter in Baltimore was fined $1,000 for shipping a drug named "Sacro-Disc-30" in interstate commerce. The labeling did not bear adequate directions for use, but unwarrantedly implied that the drug was effective in the treatment of disc and sacroiliac ailments. ◄

Open-eyed nights

Too tense to sleep...too tired to get up. Early to bed, late to rise, and not much sleep at that, the patient with severe psychic tension is understandably tired. His tensions and overreactions to the day's stresses may interfere with proper sleep, and his inability to face the day's activities can produce an ever-worsening pattern.

By relieving psychic tension, Valium® (diazepam) facilitates sleep, particularly with an h.s. dose. In many patients, the usefulness of Valium has been demonstrated in relieving psychic tension alone or with secondary depressive symptoms. Valium is generally well tolerated and, with proper maintenance dosage, usually does not unduly impair mental acuity or ability.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindications: Known hypersensitivity to drug; children under 6 months of age; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in treatment of psychotic patients, and should not be employed in lieu of appropriate treatment. As with most CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may also be associated with temporary increase in frequency and/or severity of seizures. Advise patients against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance. Keep addiction-prone individuals (such as drug addicts or alcoholics) under careful surveillance because of their predisposition to habituation and dependence. Use of any drug in pregnancy, lactation or in women of childbearing age requires that potential benefit be weighed against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants. Employ usual precautions in the severely depressed or in those with latent depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

Adverse Reactions: Side effects most commonly reported: drowsiness, fatigue and ataxia. Infrequently encountered: confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo and blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of the drug should be discontinued. Because of isolated reports of neutropenia and jaundice, periodic blood counts and liver function tests are advisable during long-term therapy. Minor changes in EEG patterns (low-voltage fast activity) observed during and after therapy and are of no known significance.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50, 100 and 500.

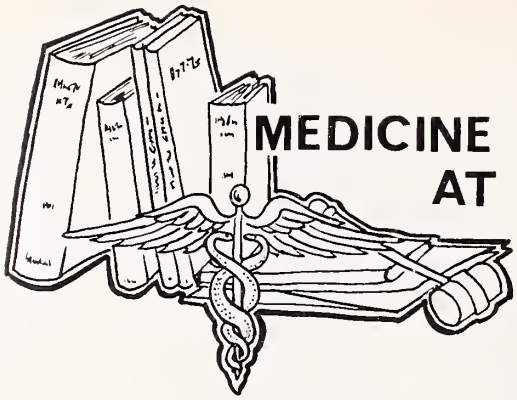
ROCHE

Roche® LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Valium® (diazepam)

useful for the relief of psychic tension, alone or with associated depressive symptoms



MEDICINE AT LAW

Hospital Not Liable for Visitor's Fall—A visitor was not entitled to recover damages in a suit against a hospital for injuries sustained when she fell on steps leading from the hospital parking lot, a Georgia intermediate appellate court ruled. The facts alleged in the complaint failed to state a cause of action.

The visitor's allegation that she was at the hospital for the purpose of visiting the premises did not show that she was an invitee or a business visitor. No other facts were alleged that showed that she was an invitee or that the hospital owed her any duty greater than that owed a licensee. The visitor alleged that her fall was due to the hospital's negligence in failing to light the steps properly. As a licensee, the visitor could not recover by showing ordinary negligence on the hospital's part, but was required to show that the hospital willfully and wantonly injured her. —*Hospital Authority of City of Bremen v. Morelli*, 156 S.E.2d 667 (Ga., June 19, 1967).

Christian Scientist Guilty of Manslaughter in Daughter's Death—A Massachusetts trial court jury found a Christian Scientist guilty of manslaughter for having caused the death of her five-year-old daughter from pneumonia by failing to provide her with medical care. Acting in accordance with the precepts of her faith, the mother did not call in a physician, but relied on prayer and assistance of a Christian Scientist practitioner. The theory on which the prosecution based its case was that the mother had a duty, under common law and the statutes, to provide her daughter with proper care, including medical care, and that her breach of that duty caused the daughter's death. It was reported that the conviction will be appealed to a higher court.—(News Release, Quincy, Massachusetts, Nov. 10, 1967).

Pediatrician Not Liable for Failure to Treat PKU With Diet—A pediatrician was held not liable for mental retardation resulting from his allegedly negligent failure to diagnose and treat a child's PKU disease. Medical experts testified that dietary treatment of the disease, accepted as proper at the time the child became ill, was no longer believed by some physicians to be effective. The testimony was admissible, a federal appellate court ruled, to show that failure to use the dietary treatment did not result in damage to the child. A jury verdict in favor of the pediatrician, in a suit brought by the child's guardian, was upheld. In the same decision, the court affirmed dismissal of another suit against the pediatrician, filed by the patient's parents, on the ground that it was barred by the two-year tort statute of limitations.

The child was two years old when he was first taken to the pediatrician in October, 1961. The pediatrician treated him until May, 1963. During that period the patient was considered mentally slow, but the pediatrician made no tests to determine the cause of his mental condition. The pediatrician testified that, since he was not trained in the field of retardation, he did not treat patients for it, but referred them to the state mental retardation center.

On July 30, 1963, the patient was taken to another physician, who made a test which disclosed that he was suffering from PKU disease. His parents took him to a medical center in another city on August 28, 1963. The diagnosis of PKU disease was confirmed, and the parents were told that the patient was severely mentally retarded as a result of the disease and could not be cured.

The following facts were established by stipulation or by the evidence: the patient had had PKU from birth and was mentally retarded when the disease was diagnosed; PKU is treatable if treatment is administered early in the child's life; when the patient's PKU was discovered, his brain damage was so advanced that his mental retardation was permanent and further treatment would not have been helpful; the medical profession in the city in which the pediatrician practiced knew about PKU in a general way but was not equipped to evaluate or treat the disease. There was medical testimony that when the patient was born there was a dietary treatment in use which was generally accepted as being effective in arresting the disease and resulting in a reasonably normal life for the child. Medical experts testified that the more recent view was that the claimed benefits of the dietary treatment were unproven and questionable. However, there was also expert testimony that the dietary treatment was still considered to be effective.

Since the testimony of the witnesses as to effective treatment of PKU was directly conflicting, the

respective weight to be given their testimony was for the jury, the court said.

The patient contended that the trial court permitted a prejudicial double standard of proof in that it required the pediatrician's liability to be determined by the generally accepted method of diagnosing and treating PKU during the period that he treated the patient, while permitting the pediatrician's expert witnesses to testify that they were, because of research since the treatment's termination, of the opinion that the dietary treatment was not effective in treating PKU. The patient argued that the duties and liabilities were to be determined by conditions as of the time of the injuries, and that proof of a change in conditions after the injury was not admissible. The fallacy of the argument, the court said, was that there was no change in the actual conditions on which the patient was seeking to base liability. The change was in the opinion of the medical profession with respect to the effectiveness of the dietary treatment. The purpose of the testimony on later research was not to establish the standard of care but to show that the failure to diagnose the PKU and prescribe the dietary treatment was not the cause of the child's mental retardation.

The suit was filed on October 8, 1965. The parents' cause of action was properly dismissed under the tort statute of limitations, because it was filed more than two years after they learned that the patient was mentally retarded and that the condition was permanent. The parents were put on notice of the pediatrician's alleged negligence not later than August 28, 1963, when the medical center confirmed the diagnosis of PKU disease and reported that the patient suffered from mental retardation that could not be cured.—*Lewis v. Owen*, Docket No. 9541 (C.A. 10, Jan. 15, 1968). (Reference: John R. Richards, Esq., of Houston, Klein and Davidson, 404 South Boston, Tulsa, Oklahoma 74103.)

Discovery Doctrine Applied in "Foreign Body" Suit—A patient's suit against a physician and a hospital for injuries caused by their alleged negligence in having left a hemostat in her body during surgery was held not barred by the two-year personal injury statute of limitations. The statute did not begin to run until the patient discovered, or reasonably should have discovered, the existence of the cause of action, a Delaware trial court ruled.

The surgery was performed in 1958. The patient's recovery was uneventful. In 1965, when the patient began to suffer abdominal pains, an emergency operation was performed, which disclosed the hemostat's presence. It was undisputed that the patient's first onset of pain was in 1965, and that reasonable care and diligence on her part would not have led to the discovery of the hemostat before that time.

This case was analogous to a case of fraudulent concealment, the court said. Where there is fraudulent concealment, the statute of limitations is tolled until the cause of action is discovered or could, by the exercise of reasonable diligence, have been discovered. In a suit by a patient against a physician or a hospital, the discovery doctrine is applicable when the following factors are present: (1) there is a physical invasion of the body by a foreign object which is continuing in nature; (2) the continuing invasion is due to negligence in the performance of the surgery; (3) the negligence permitting the invasion is concealed by the very surgery in which the invasion occurs; (4) there exists a professional medical relationship with the patient. In such circumstances, the court said, there is a "negligent surgical concealment of a foreign object." Since the four necessary factors were present in this case, the discovery doctrine was applicable, even though there was no allegation of fraudulent concealment.

The application of the doctrine admittedly gives rise to a problem of stale evidence. This problem could be minimized, the court said, if hospitals and physicians would develop a system of records that depicted in detail the procedure used in a given operation.—*Allen v. Layton*, 235 A.2d 261 (Del., Nov. 2, 1967).

Compulsory Polio Immunization Statute Upheld—A chiropractor's refusal to have his four children immunized against poliomyelitis so that they could attend school constituted "neglect," a New York trial court ruled. The statute requiring immunization was held constitutional, and immunization was not contrary to the tenets of the religious sect of which the chiropractor was a member.

The statute requires immunization against poliomyelitis as a condition of attendance at all schools, public or private, in the state, except as to children whose parents are bona fide members of a religious organization whose teachings are contrary to the practice of immunization. The chiropractor refused to have his children immunized on the ground that the practice was contrary to the doctrines and beliefs of the Methodist Church, of which he was a member. However, his minister testified that immunization against poliomyelitis was not contrary to any of the teachings or beliefs of the Methodist Church. Therefore, the statutory exemption did not apply.

Requiring immunization as a condition for admission to school constituted a valid exercise of the police power on the legislature's part. People may differ as to the efficacy and necessity of the immunization or as to whether it is medically wise or unwise. However, it is the com-

mon belief of the people of the state that immunization is an effective preventive of poliomyelitis. It is that common belief that the legislature has expressed through the statute. It was immaterial that the disease did not exist in the community at the time that the statute was enacted. The legislature may, under the police power, take steps to prevent the onset of a disease.—*In re Elwell,* 284 N.Y.S.2d 924 (N.Y., Nov. 29, 1967).

Citation Editor's Note: A news release reports that the chiropractor has changed his religion from Methodist to the Universal Religious Brotherhood, which opposes all types of immunization. He states that the State Education Department has now ruled that he may send his children to school without immunization.—News Release, Poughkeepsie, N.Y., Feb. 4, 1968.

Punitive Damages Denied for Unauthorized Circumcision— Punitive damages could not be recovered in a suit against a hospital and physicians for the unauthorized circumcision of a newborn child, the Oregon Supreme Court ruled. The evidence failed to establish that the circumcision resulted from the hospital's and the physicians' aggravated disregard of their duties. Judgment against the hospital and physicians for negligence was affirmed, with the award of punitive damages deleted.

At a prenatal conference, the parents told a physician on the hospital staff that they did not want the child circumcised. The physician noted the information on the mother's medical record. When she was admitted to the hospital for the delivery, the mother told the admissions clerk the same thing. The admission records, which were supposed to go to the delivery room with the mother, were stamped "Circumcision Not Authorized." The child was delivered by a resident under the supervision of a staff physician. The physician left the delivery room after the delivery, and the resident circumcised the child. The hospital informed the parents that same day that the circumcision had been performed. There was no claim that the circumcision was improperly performed or that any physical injury resulted therefrom.

The hospital and physicians did not contend that the parents had authorized the circumcision or that they had not been informed that no circumcision was to be performed. The jury returned a verdict in favor of the patient, and the hospital and physicians appealed only that part of the judgment which awarded punitive damages.

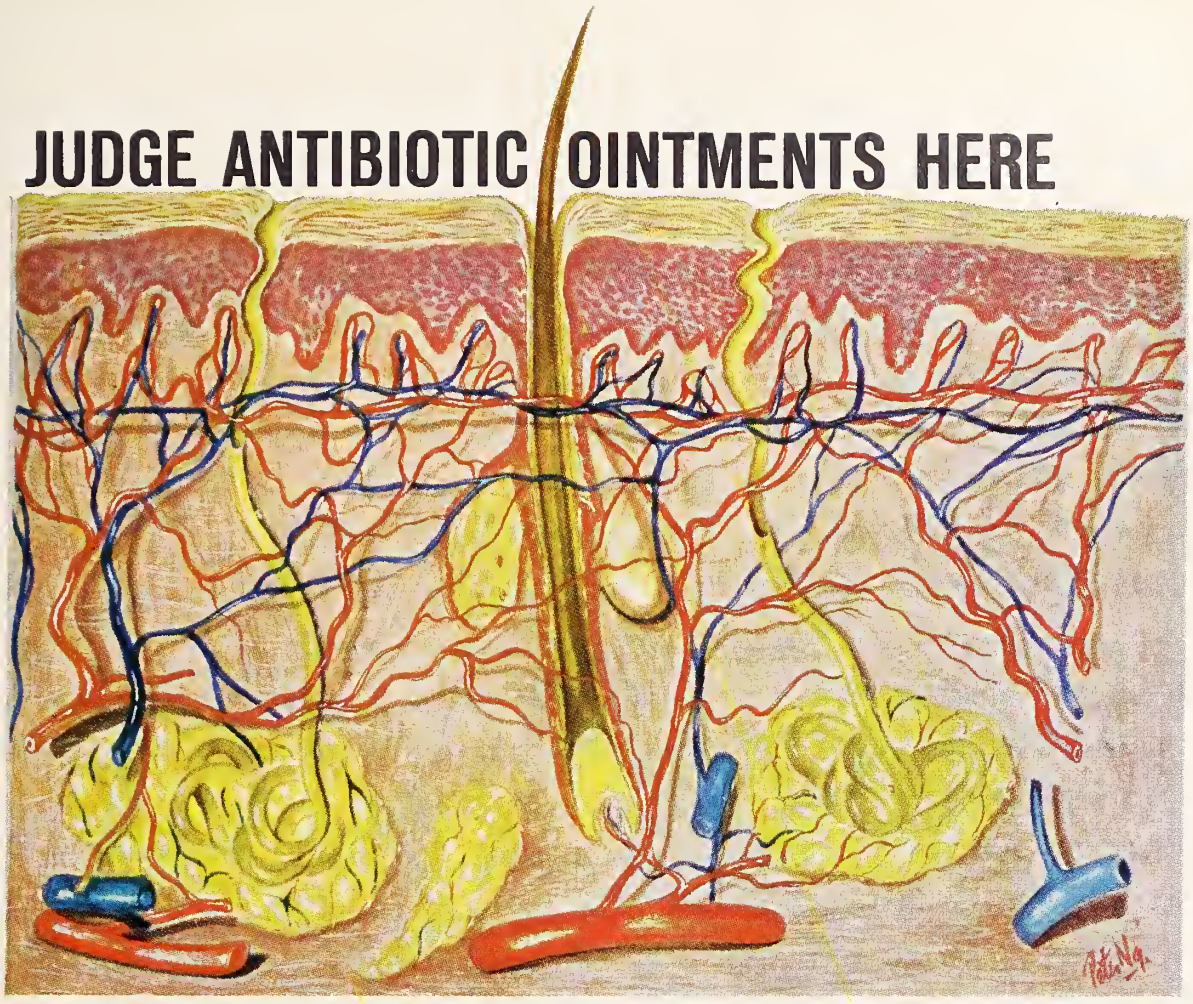
Punitive damages can be justified only on the theory of deterrence, where the violation of societal interests is sufficiently great and of a kind that sanctions would tend to prevent. Prior cases have held punitive damages proper where there has been a particularly aggravated disregard by a member of the medical profession of his professional duty to preserve life and health. Although there was no rational justification for any special rule applicable to the medical profession, the duty owed by the offending party must be taken into consideration in determining whether there has been a sufficiently aggravated violation of societal interests to justify the imposition of punitive damages.

In this case, the resident testified that she had asked and been told that a circumcision had been authorized, but the person she asked was not produced to confirm her testimony. The resident testified that she had not seen the admission records, but subsequently testified as to a notation that was in them. However, the evidence did not establish whether she knew of the notation because she had seen it or because she had been told of it. The mother testified that two days after the delivery, the resident denied having delivered the child. The father testified that he had been unable to get information from the hospital as to who performed the circumcision and why it had been done.

Inconsistent, evasive, and untruthful statements made subsequent to an event are evidence only of an attempt to avoid responsibility for past actions, rather than evidence of a previous disregard for consequences, the court said. The record was wholly lacking in evidence of an aggravated disregard by the hospital or the physicians of their duties. There was thus no basis for an award of punitive damages.—*Noe v. Kaiser Foundation Hospitals,* 435 P. 2d 306 (Ore., Dec. 13, 1967).

Physicians' Group Held Taxable as Corporation—A professional corporation set up by 14 radiologists to provide services to hospitals and individual patients was held by a federal trial court in Ohio to be entitled to the tax advantages of a corporation. This is the second time a federal court has held invalid the Treasury Department's Kintner regulations, which restrict professional groups in obtaining corporate tax status. The first decision was handed down by the federal district court in Colorado in Empey v. U.S. ◄

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

New

Therapeutic breakthrough in non-narcotic control of the pain of trigeminal neuralgia

Tegretol®
carbamazepine

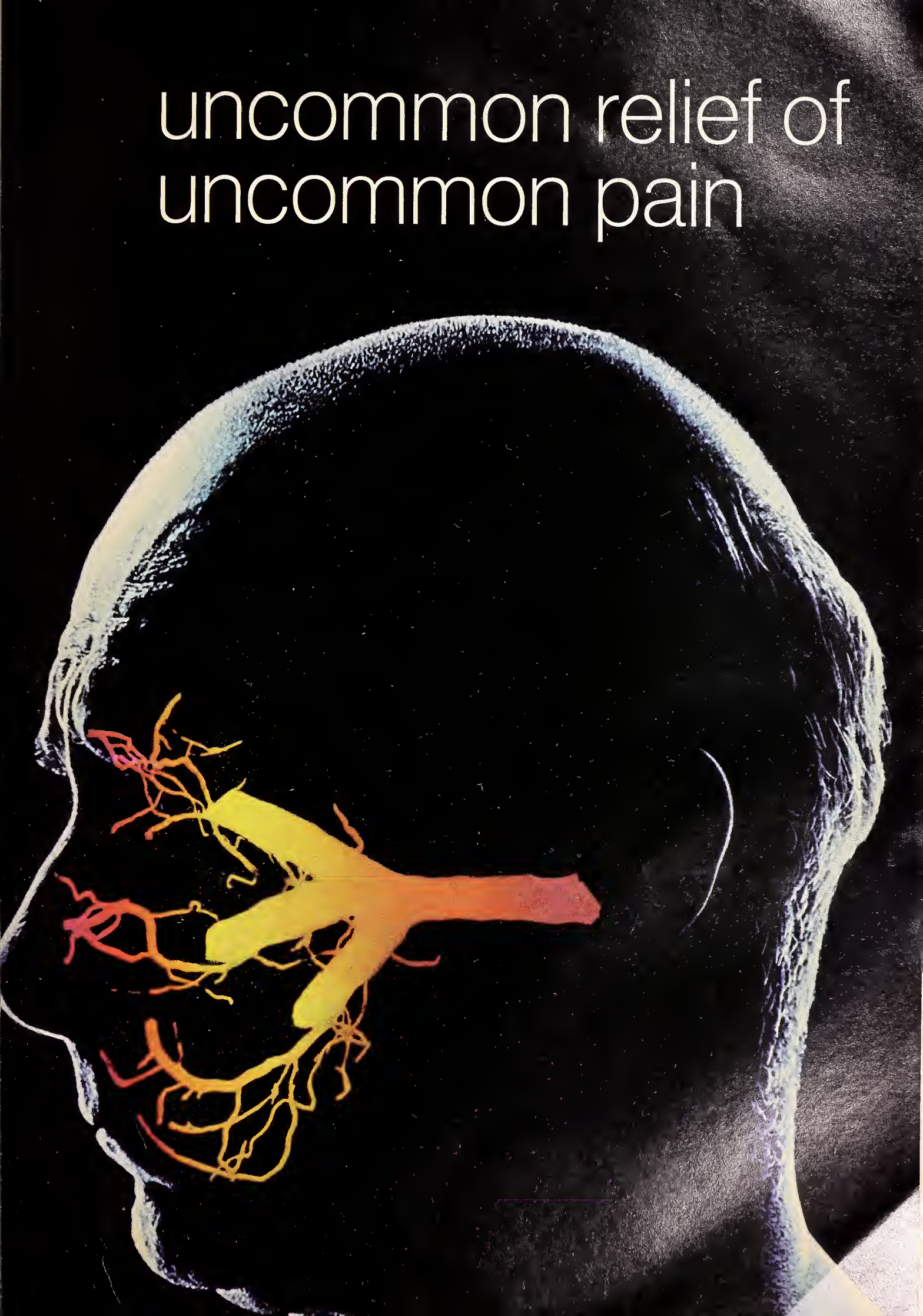
Warning
Fatal cases of aplastic anemia have been reported following treatment with Tegretol. Agranulocytosis, thrombocytopenia and transitory leukopenia have also been observed.
Complete blood and platelet counts should be done prior to and at regular intervals during treatment with the drug (see recommendations under "Important Note and Precautions") to help in the early detection of serious bone marrow injury. Abnormalities in initial blood tests should rule out use of the drug. Also, patients should be made aware of such early toxic signs of a potential hematologic problem as fever, sore throat, mouth ulcers, easy bruising and petechial or purpuric hemorrhage. Should such signs appear, the patient should be advised to discontinue the drug and to report to the physician immediately.

Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.
Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.
Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.
Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.
In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.
Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect.
Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.
Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.
Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.
Before initiating therapy, the following laboratory procedures should be performed:
1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.
2. Baseline evaluations of liver function.
During treatment with Tegretol, the following laboratory procedures should be performed:
1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent laboratory and clinical evaluations. Should this trend continue, the drug should be discontinued.
2. Liver function tests must be performed at regular intervals during treatment with this drug since liver damage may occur during therapy. The drug should be discontinued immediately in cases of aggravated liver dysfunction or active liver disease.
3. Periodic eye examinations, including slit-lamp, funduscopy and tonometry, are recommended for patients being treated with this drug since many phenothiazines and related drugs have been shown to cause eye changes.
4. Complete urinalysis and BUN should be done on patients treated with Tegretol because of observed renal dysfunction.
Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet, nausea, vomiting, aplastic anemia, transitory leukopenia, agranulocytosis, eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalities in liver function tests, cholestatic and hepatocellular jaundice, urinary frequency, acute urinary retention, oliguria with elevated blood pressure, albuminuria, glycosuria, elevated BUN, microscopic deposits in the urine, impotence, disturbances of coordination, confusion, headache, fatigue, blurred vision, transient diplopia and oculomotor disturbances, speech disturbances, abnormal involuntary movements, peripheral neuritis and paresthesias, depression with agitation, talkativeness, nystagmus, tinnitus, paralysis and other symptoms of cerebral arterial insufficiency, pruritic and erythematous rashes, urticaria, Stevens-Johnson syndrome, photosensitivity reactions, alterations in skin pigmentation, exfoliative dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, erythema multiforme and nodosum, aggravation of disseminated lupus erythematosus, gastric distress, abdominal pain, diarrhea, constipation, anorexia, dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills, adenopathy, lymphadenopathy, aching joints and muscles, leg cramps, conjunctivitis, left ventricular failure, aggravation of hypertension, hypotension, syncope and collapse, edema, aggravation of coronary artery disease and congestive heart failure. (Whether these cardiovascular effects are drug-related is not known. However, some of these complications have resulted in fatalities.) The necessity for discontinuing the drug should be dictated by the gravity and severity of the adverse reactions.
Dosage and Administration The drug should always be taken with meals, if possible.
Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, the dose should be increased in one-half tablet (100 mg.) increments every 12 hours until freedom from pain is achieved. To relieve pain, between 200 mg. and 1200 mg. per 24 hours may be necessary.
Maintenance: Initial control of pain can be maintained in most patients with a dose of 400 mg. to 800 mg. daily. Maintenance doses may range between 200 mg. and 1200 mg. daily.
At least once every 3 months during treatment period attempts should be made to discontinue the drug or to reduce the dose to the minimum effective level.
Availability Round, white, single-scored tablets of 200 mg. in bottles of 100 and 1000. (B)46-820-A
For complete details, please see Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Geigy

uncommon relief of uncommon pain



A little

Just one 50 or 100 mg.
tablet in the morning can
work a long diuretic day
in edema and hypertensi

HY-6113

Hygroton® can work a long day too

chlorthalidone

hat's because of its prolonged tion, usually providing smooth uretic activity throughout the day. nd one-a-day dosage, in the ng run, means few tablets to take nd few tablets to pay for.

Hygroton, brand of chlorthalidone, may mean troublesome side effects for certain patients. And you can't prescribe it in cases of demonstrated hypersensitivity to the drug or in severe renal or hepatic diseases.

Before writing it for your patients, please check the Prescribing Information. It's summarized on the next page.

Hygroton

chlorthalidone in edema and hypertension

Geigy

in edema and hypertension

A little Hygroton® can work a long day

chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant patients. Since the drug may cross the placental barrier, adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, hyperuricemia, headache, muscle cramps, orthostatic hypotension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.

(B)R2-46-230-D

For full details, please see the complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

HY-6113

Changes in Blue Shield Payment Patterns

(One of a series prepared by Blue Shield)

The table below graphically indicates changes in Blue Shield payment patterns, analyzed in terms of medical classifications. For example, anesthesia, diagnostic and psychiatric benefits were not available in 1949. In 1967, anesthesia payments totaled $2,270,678, and diagnostic payments reached $3,986,803. Payments for in-hospital medical services increased from $8,411 in 1949 to $3,427,930 in 1967. Psychiatric services appeared in the table for the first time in 1967, in an amount totaling $195,071. Blue Shield Medicare Supplements for the year were $2,716,394.

MEDICAL CLASSIFICATION	AMOUNT PAID 1949	1967
SURGICAL:		
T & A	$ 144,955	$ 760,763
Eye, Ear, Nose & Throat	72,388	1,545,418
Appendectomy	205,840	458,941
Hernia	42,690	817,295
Abdominal	91,910	1,494,588
Proctology & Urology	109,518	1,673,455
Orthopedics	114,395	2,479,240
Radiation Therapy	9,786	235,835
All Other Surgical	110,903	4,101,765
Total Surgical	$ 902,386	$13,567,300
PSYCHIATRIC:	*	$ 195,071
MEDICAL:	$ 8,411	$ 3,427,930
MATERNITY:		
Deliveries	$ 259,764	$ 2,393,243
Gynecology	261,854	2,064,958
Total Maternity	$ 521,618	$ 4,458,201
ANESTHESIA:	*	$ 2,270,678
DIAGNOSTIC:	*	$ 3,986,803
MEDICARE SUPPLEMENT:	—	$ 2,716,394
GRAND TOTAL	$1,432,415	$30,622,378

* These benefits were not available in 1949.

W. C. Huddlestone
Public Relations

WANTED: Physicians Locations

GENERAL PRACTICE

Jan Baumgardner, 801 Grand View, Alexandria, Va. 22305

Dean R. Bahler, 104 Mohawk Lane, West Lafayette, Ind. 47906

Thomas M. Zurkowski, 6303 Leith Walk, Baltimore, Md.—available 7/1969

Ahmad Alrikabi, 244 E. Pearson St., Chicago, Ill. 60611

M. S. Quadir, 256 Fowler Ave., Jersey City, N. J. 07305—also *General Surgery*

SPECIALISTS

John F. Weldon, 122 Rodgers St., Monongahela, Pa. 15063—*Anesthesiology*

Craddock Duren, Henry Ford Hospital, Detroit, Mich. 48202—*Internal Medicine*

Delbert H. Meyer, 8220 Cedar Crest Way, Sacramento, Calif. 95826—*Internal Medicine*

Cristobal G. Duarte, 1300 York Ave., D-317 New York, N.Y. 10021—*Internal Medicine*

John D. Byriacopoulos, 3112 Windsor Terrace, Oklahoma City, Okla.—*Internal Medicine*

A. Reid Allison, Jr., 1109 W. Beaver Ave., State College, Pa. 16801—*Internal Medicine*

James L. Auckley, 205 Tinker Dr., Fort Worth, Texas 76114—*Internal Medicine*

Joseph G. Piroch, U.S. Naval Hospital, Pensacola, Fla. 32512—*Internal Medicine*

Pedro J. Viera, 2259 Priscilla, St. Paul, Minn. 55108—*Neurology*

Continued

WANTED

Continued

Pedro Rafael de la Rosa Gomez, 4433 Pershing, St. Louis, Mo. 63108—*OB-GYN*

William R. Armstrong, USAF Hospital, Maxwell AFB, Ala. 36112—*Ophthalmology*

Robert L. Cosentino, 42-B Creekside Dr., Cheektowaga, New York—*Ophthalmology*

Nikolas S. Zografov, 3648 Rockingham, Royal Oak, Mich. 48072—*Orthopedics*

Donald H. Holder, 3412 Curtis Dr., Hillcrest Heights, Md. 20023—*Orthopedics*

Lorenzo Marcolin, 58 Broadfield Dr., Etobicoke, Ontario—*Orthopedics*

Eric R. Oches, 412 Upland Rd., Baltimore, Md. 21208—*Pediatrics*

Charles R. Block, U.S. Naval Hospital, FPO San Francisco, Calif. 96630—*Pediatrics*

William J. Frizzell, 7239 Winton Rd., Cincinnati, Ohio 45224—*Radiology*

James C. Engle, 7516 Folger Dr., Charlotte, N.C. 28211—*General Surgery—Thoracic and Cardiovascular*

Masood Akhtar, 4100 W. Third St., Dayton, Ohio 45428—*General Surgery*

Hoo Joon Cheung, 52 Myrtle St., Pawtucket, Rhode Island 02860—*General Surgery or Research*

Jack L. Kelley, 4513-1 O'Donnell Hgts., Fort Riley, Kan. 66442—*General Surgery*

Franklin M. Soriano, Jr., 1026 Park Ave., Bridgeport, Conn. 06604—*General Surgery with General Practice*

John H. DeTar, 190 Mill St., Reno, Nev. 89501—*Urology*

Eriks P. Birzgalis, 2968 Treen Ct., Ranco Cordova, Calif. 95670—*Urology*

Paul K. Greening, 5120 Burt, Omaha, Neb. 68132—*Industrial, Medical Legal Insurance*

Paulo P. de Mendonca, Univ. of Maryland Hospital, Baltimore, Md. 21201—*Research Medicine—Surgery*

Ralph C. Bailey, Pearl Star Route, Gatesville, Texas 76528—*Student Health*

ADDITIONAL LOCATIONS

GENERAL PRACTICE

County Town

Bartholomew County—COLUMBUS—population 25,900—located 43 miles south of Indianapolis on U.S. 31. 184 bed hospital. Number of industries. Need for physicians doing general practice. Contact president or secretary of the Bartholomew-Brown County Medical Society—H. W. Richmond, M.D., President, Cummins Engine Company or C. David Ryan, M.D., 2600 Sandcrest Blvd., Secretary.

Cass County—LOGANSPORT—population 20,900. Located in the north central part of Indiana 70 miles north of Indianapolis. Two hospitals. Contact E. L. TerBush, M.D., 216 Ninth Street, Logansport.

Daviess County—WASHINGTON—population 10,800. 137 bed county hospital. Contact H. B. Lindsay, M.D., Secretary, Daviess-Martin County Medical Society, 511 E. Main St., Washington 47501.

Howard County—KOKOMO—population 49,900. Two hospitals. Located in north central Indiana, 50 miles north of Indianapolis on U.S. 31. Contact Jerome F. Doss, M.D., Secretary, Howard County Medical Society, 3520 S. Lafountain, Kokomo, Indiana 46901.

Jay County—PORTLAND—county seat town with a population of 7,500. Located 30 miles north of Muncie, home of Ball State University. Need for two general practitioners. 100-bed fully accredited hospital. Office available. Contact E. M. Gillum, M.D., 522 W. Arch Street, or Warren Phemister, Administrator, Jay County Hospital, Portland—telephone 726-7131.

Jefferson County—MADISON—population 11,600 located in the southern part of Indiana on the Ohio River. Large number of industries and farming is also a major industry. One hospital—109 beds. Contact Ott B. McAtee, M.D., Secretary, Jefferson-Switzerland County Medical Society, Madison State Hospital, Madison 47250.

Kosciusko County—MENTONE—population 800. Located in the northern part of Indiana in the lake region close to three county seat towns with hospital facilities. Fully equipped office available. One other physician in the community. Contact Mrs. Dan Urschel, P.O. Box 307, Telephone Area Code 219 - 353-4305.

WARSAW—population (County Seat) 7,300. Located in the lake region of northern Indiana. One hospital. Contact Robert Dormire, M.D., 827 S. Union, Warsaw or Arthur L. Moser, M.D., 600 E. Winona, Warsaw 46580.

Lake County—LAKE COUNTY located in the northwestern part of Indiana close to Chicago. Industrial area. Openings for general practice. Several clinic groups need physicians. The Lake County Medical Society tries to keep a running record of openings and the society can be contacted for referral. Contact Mr. John B. Twyman, Ex. Director, Lake County Medical Society, 4640 W. Fifth Ave., Gary, Ind. 46406.

Madison County—PENDLETON—population 2,500. The expanding Pendleton community is experiencing a rapid growth in its suburban residential area and is in need of an additional general practitioner. A suitable building is available located in downtown Pendleton. Two modern hospitals within ten minutes. Pendleton is located in central Indiana. Contact Mr. John C. McLaughlin, Pendleton Chamber of Commerce, Pendleton 46064.

St. Joseph County—SOUTH BEND and surrounding area. Population of South Bend 135,700. Two hospitals in South Bend and one in Mishawaka. Physicians interested in exploring the possibilities in the St. Joseph County area should contact Mr. Harry C. Davis, Ex. Secretary, St. Joseph County Medical Society, 106 W. Monroe St., South Bend, Ind. 46601.

Opening for full time physician at Healthwin Hospital (TB & Chronic Diseases). Contact E. W. Custer, M.D., Healthwin Hospital, 20531 Darden Road, South Bend 46637.

Scott County—AUSTIN—located in south central part of Indiana. The principal economy is industry. Located five miles from Scottsburg and 20 miles from Seymour where hospital facilities are available. Contact Mrs. Joe Shields, R.R. #1, Austin 47102.

Spencer County—ROCKPORT—population 2,500. Located in the southwestern

part of Indiana. County population 16,0000 to 17,000 with only three practicing physicians. Contact M. O. Monar, M.D., or J. C. Glackman, M.D., Rockport 47635.

Sullivan County—SULLIVAN—population 5,000. One hospital—104 beds. Contact Mr. William Sluder, Administrator, Mary Sherman Hospital, Sullivan 47882.

Vanderburgh County—EVANSVILLE—population 144,400. Located in the southwestern part of Indiana on the Ohio River. Three hospitals. More physicians needed in the field of general practice. Contact Arthur P. Tiernan, Executive Secretary, Vanderburgh County Medical Society, 109 S. E. Third Street, Evansville 47708.

White County—MONTICELLO——population 6,000—county seat town with a 48-bed county hospital. Need for two general practitioners. Contact W. M. Dickerson, M.D., President, White County Medical Society, 1114 O'Connor Blvd., Monticello 47960.

SPECIALISTS

County Town

Bartholomew County—COLUMBUS—population 25,900, located 43 miles south of Indianapolis on U.S. 31. 184-bed hospital. Number of industries located in the community. There are openings for general practice, internal medicine, ophthalmology, orthopedics, pediatrics and surgery. Contact President or Secretary of the County Medical Society—H. W. Richmond, M.D., Cummins Engine Co., President and C. David Ryan, M.D., 2600 Sandcrest Blvd., Columbus 47201, Secretary.

Cass County—LOGANSPORT—population 20,900. Located in north central part of Indiana 70 miles north of Indianapolis. Two hospitals - Memorial Hospital - 98 beds and St. Joseph Hospital - 117 beds. Openings for:

General Practice - contact E. L. TerBush, M.D., 216 Ninth St.

Anesthesiology - contact J. C. Jones, M.D., 420 North St.

Ear, Nose & Throat - contact F. W. Parker, M.D., 2400 E. Broadway

Internal Medicine - contact J. C. Jones, M.D., 420 North St.

Ophthalmology - contact Camille Parker, M.D., 2400 E. Broadway

Orthopedics - contact J. C. Jones, M.D., 420 North St.

Pathology - contact R. L. Glendening, M.D., 420 A High St.

Psychiatry - contact R. W. Maschmeyer, M.D., Longcliff State Hospital.

Daviess County—WASHINGTON—population 10,800. 137 bed county hospital. Openings available for the following specialities:

General Practice - Contact H. B. Lindsay, M.D., 511 E. Main St.

Anesthesiology - Contact H. D. Norton, M.D., 511 E. Hefron St., and Daviess County Hospital

Allergy —

Dermatology —

Psychiatry —

Surgery —

Urology —

Contact H. B. Lindsay, M.D., Secretary,
Daviess-Martin County Medical Society,
511 E. Main Street, Washington 47501

Henry County—NEWCASTLE—population 21,600. 194 bed hospital. Openings for

General Practice —

Contact Cloyd Dye, M.D., New Castle Clinic, 1007 N. 16th St. and Benjamin Harrison, M.D., 540 S. Main St., New Castle

Dermatology —

Ear, Nose & Throat —

Internal Medicine —

Obstetrics —

Ophthalmology —

Orthopedics —

Psychiatry —

Contact Cloyd Dye, M.D., New Castle Clinic, 1007 N. 16th Street, New Castle

Urology —

Contact Doctor Dye and Robert Amos, M.D., 540 S. Main St., New Castle

Howard County—KOKOMO—population 49,900. Two hospitals—one 148 beds and the other 223 beds. Openings for:

General Practice —

Anesthesiology —

Ear, Nose & Throat —

Internal Medicine —

Ophthalmology —

Psychiatry —

Contact Jerome F. Doss, M.D.,
Secretary,
Howard County Medical Society,
3520 S. Lafountain,
Kokomo, Indiana 46901

Lake County—Located in the northwestern part of Indiana close to Chicago. Industrial area. Shortage exists in every category. Several clinic groups need physicians. The Lake County Medical Society tries to keep a running record of openings and the society can be contacted for referral. Contact Mr. John B. Twyman, Ex. Director, Lake County Medical Society, 4640 W. Fifth Ave., Gary, Ind. 46406.

St. Joseph County—SOUTH BEND—and vicinity. Population of South Bend 135,700. Two hospitals in South Bend and one in Mishawaka. Community needs and could use general practitioners, physicians specializing in allergy, anesthesiology, dermatology, ear, nose and throat, internal medicine, neurology, neurosurgery, obstetrics, ophthalmology, orthopedics, pediatrics, psychiatry. Physicians interested in exploring the possibilities in the St. Joseph County area should contact Mr. Harry C. Davis, Ex. Secretary, St. Joseph County Medical Society, 106 W. Monroe St., South Bend, Ind. 46601.

Jefferson County—MADISON—population 11,600 located in the southern part of Indiana on the Ohio River. Large number of industries and farming is also a major industry. One hospital—109 beds. Excellent openings and needs in Madison for the following—general practitioners (one or more), ophthalmologist, dermatologist and pediatrician. Contact Ott B. McAtee, M.D., Secretary, Jefferson-Switzerland County Medical Society, Madison State Hospital, Madison, Ind. 47250.

Vanderburgh County—EVANSVILLE—population 144,400. Located in the southwestern part of Indiana on the Ohio River. Three hospitals. More physicians needed in the fields of general practice, allergy, anesthesiology, dermatology, ear, nose and throat, internal medicine, neurology, neurosurgery, ophthalmology, orthopedics, pediatrics and psychiatry. Any physician in these specialties would have no difficulty in building a lucrative practice within a short time. Contact Arthur P. Tiernan, Executive Secretary, Vanderburgh County Medical Society, 109 S. E. Third St., Evansville 47708. ◄

ABSTRACTS, BOOK REVIEWS

FOOT DISORDERS— MEDICAL AND SURGICAL MANAGEMENT

Nicholas J. Giannestras, M.D., Lea & Febiger, Philadelphia, 1967; 465 pp.; $22.00.

Here is a valuable reference for orthopedic surgeons, general practitioners and podiatrists or a worthy textbook for medical or podiatry schools. The book is authored by Dr. Giannestras backed up by a dozen well known contributors. There are 465 illustrations —all well done.

There are chapters on anatomy, physiology, definitions, the normal foot's development and care. Eighteen further chapters concern problems of the foot. Some are: the pronated foot in childhood, the foot in cerebral palsy, hallux valgus and hallux rigidus, fractures of the foot, the more common dermatologic disorders of the foot, circulatory disturbances of the foot, etc.

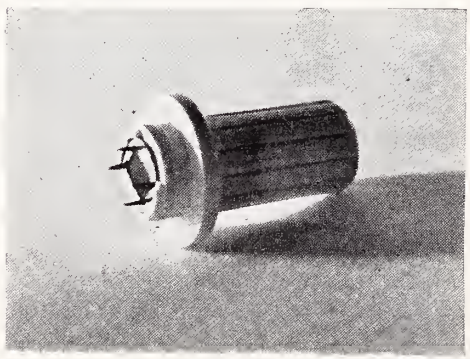
The book is well written, easy-to-read, and authoritative. Interspersed are axiomatic statements such as the patient with foot trouble will be cooperative if it is explained that "the therapeutic regimen which will be prescribed for him will relieve most of his symptoms but will not cure him . . . ." and concerning clubfoot "Regardless of how severe the forefoot adduction and supination may be, as long as the heel is supple, it is not a true clubfoot." Concerning calluses, etc., "In a diabetic with recurrent trophic ulcer under the metatarsal head, which heals with rest and reappears with weight bearing, one should not consider metatarsal shortening under any circumstance."

In summary it is a good book for all concerned.

ALVIN J. HALEY, M.D.
Fort Wayne

To fight TB- find it first!

Make tuberculin testing routine with every physical examination.



TUBERCULIN,TINE TEST (Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

Lederle

330—8/6135

THE BALKAN NEPHROPATHY

Ciba Foundation Study Group, In honor of Prof. Dr. Frano Bulic, edited by G. E. W. Wolstenholme and Julie Knight, Little, Brown & Co., Boston, Mass. 1967; 123 pages and 29 illustrations; $2.75.

"Balkan Nephropathy" was a term new to me. This little volume intrigued me no end. Is it possible, in this day and age, to come up with a brand new entity?

Well, it did not take long to realize that this eventually fatal disease affects the inhabitants of villages that border the Danube river and its tributaries in Romania, Bulgaria and Serbia: hence the term designating a specific geographic area.

The disease is being studied intensively but the conclusions as to the etiology remain awaiting a consensus. Genetic? Hardly likely. Trace elements? Very possible but still unproven. Lead? Cadmium? Selenium? It does appear proven that the water supply is heavily implicated. Infection? Say, a fungus: by no means disproven. Plant poisons, such as "Aristolochia clematitis"? Again, —definitely under investigation.

In other words, we are dealing with a post World War II phenomenon that kills by destroying the kidneys of people living in a very specific Balkan locale. These problems have arisen before in many other countries. Given the intense studies by highly capable workers, we are reasonably certain of obtaining answers to the intriguing questions being posed.

As usual, the paper, binding and printing are excellent. The nephrologist will want it for his specialized library. Eventually, our textbooks will have a paragraph or two on *Balkan Nephropathy*.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

ATLAS OF STRABISMUS

Gunter K. VonNoorden, M.D., Edward Maumenee, M.D., The C. V. Mosby Company, St. Louis, Mo., 1967; 188 pp.; $17.50.

This book is titled as an atlas but, as Adler infers in the forward, it could be readily referred to as a textbook with excellent pictures and illustrations to clarify and compliment this text. In a logical order, the anatomy, physiology, diagnostic means of examination and sensory status are presented in the first half of the book while the second half is devoted to evaluation of the motor status and types of muscle imbalances. All of the material is presented concisely with corresponding illustrations and pictures to help the reader grasp the contents readily. Very little space is allotted to treatment and then only in general terms.

This is an excellent text for the individual first beginning the study of strabismus, but also an excellent, quick and easily grasped review for the seasoned ophthalmologist.

ALFRED A. WICK, M.D.
Fort Wayne

CARDIOVASCULAR PHYSIOLOGY

Robert M. Berne, M.D., Matthew N. Levy, M.D., C. V. Mosby Co., Saint Louis, Mo., 1967; 254 pp.; 148 illustrations; $10.75.

"This book is designed primarily for medical and graduate students." This very first sentence of the preface sets the tone for this very well printed and profusely illustrated monograph. The next question is, "on what level are the expected readers able to respond?"

Being a Ph.D. in physiology has some handicaps when reviewing this book. Thus, the discussion on cardiac electrical activity is profusely illustrated and rather clear. However, I looked in vain for the usual diagram showing the tri-axial exposition of just where and when the dipole is plus or minus. It may not be necessary to show Arrighi's tetrahedron—still, the figure on p. 30 would have been (I think) more explicable with the suggested inclusion.

On the other hand, the authors assume quite a knowledge of advanced calculus when they launch into a rather detailed analysis of the really excellent diagrams in the chapter on the "Cardiac Pump." Well, I wonder whether today's students are really so knowledgeable?

Vector cardiography just cannot be tossed off by a scant page and a half — not unless the student has a fairly good prior comprehension. On the other hand, the Fick principle (I think) can be explicated in less formidable terms than those tossed off in Chapter 9.

All this is nit picking. We have long had a need for a volume that would bring both the student, boning up for his boards, and also the aging practitioner, inquiring for the newest and latest, refreshment of soul and education of mind. This volume amply accomplishes its stated aims. The authors deserve the thanks of their reading public.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

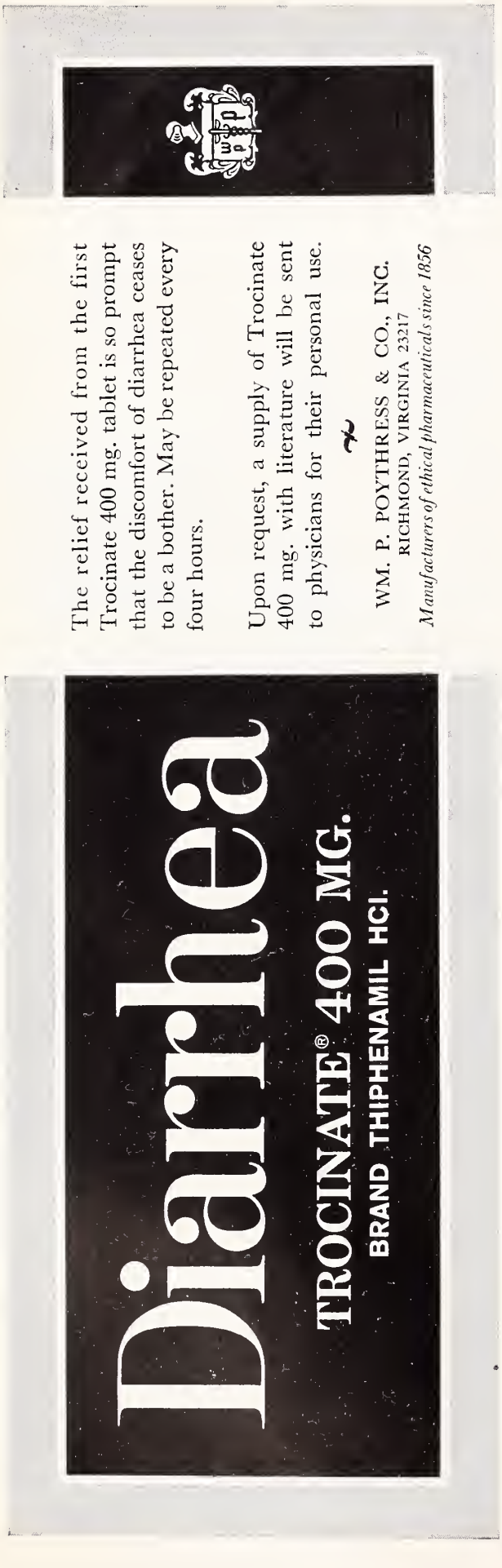
Abstracts From Various Literature, Prepared by AMA

CRYOPRECIPITATE CONCENTRATES OF FACTOR VIII FOR SURGERY IN HEMOPHILIACS

J. V. Cooke (National Institutes of Health, Bldg. 31, Bethesda, Md.), P. V. Holland, and N. R. Shulman

Ann. Intern. Med. 68:39-47, (Jan.), 1968.

Pool's original method or preparing cryoprecipitate for treating hemophilia was suitable for preparing factor VIII from acidified plasma which is a by-product of platelet concentrates. Preparation of cryoprecipitate was simplified by using residual ice crystals as a collecting filter to eliminate centrifugation and as a suspending medium to eliminate exogenous diluent. Experience with four hemophiliacs undergoing seven surgical procedures is described. Satisfactory factor VIII levels were easily maintained with cryoprecipitate in all patients and no complications were associated with its use. Recovery of factor VIII in vitro and in vivo was evaluated and therapeutic regimens that allow for variations in yield to assure hemostasis without laboratory control were out-



lined. Cryoprecipitate is superior to plasma and as effective a commercially available factor VIII concentrates but cheaper.

ALTERATION OF SUPERFICIAL BACTERIAL FLORA IN SEVERELY ILL PATIENTS

B. Stratford et al. (St. Vincent's Hospital, Melbourne)

Lancet 1:68, (Jan. 13), 1968.

Normal superficial flora has always been considered to be predominantly gram-positive cocci. This has been confirmed in ambulatory psychiatric patients and "well" surgical patients preoperatively. However, the finding in severely ill patients that their flora has altered to include a significant number of gram-negative bacilli has not previously been reported. This may be a source of the increasing number of infections due to these latter organisms presently being found in general hospitals.

OUTCOME FOR THE FETUS OF MOTHERS RECEIVING PREDNISOLONE DURING PREGNANCY

D. W. Warrell (Jessop Hospital for Women, Sheffield, England) and R. Taylor

Lancet 1:117-118, (Jan. 20), 1968.

Thirty-four pregnancies in 30 women receiving prednisolone in the course of treatment of a general disease resulted in eight stillbirths, and nine fetuses were judged to have been at risk during pregnancy or parturition. In contrast, 34 pregnancies in women not receiving glucocorticoids but with similar general diseases resulted in one stillbirth, three premature babies, and 30 healthy babies.

INVESTIGATION OF MOOD STATES IN WOMEN TAKING ORAL CONTRACEPTIVES

B. J. Murawski et al. (Harvard Medical School, Boston)

Fertil. Steril. 19:50-63, (Jan.-Feb.), 1968.

Seventy-two clinic patients on contraceptive regimen, followed for 15 months, showed no increase in depression as measured by a variety of tests and scales. Some patients did become depressed but non-pharmacological etiology could usually be discovered. Possible sedative side-effects should be investigated further. Religious background, education, and family size were not significant variables. Knowledge of magical phantasies, expectations, and motivation help the investigator to understand some patients' emotional responses to oral contraceptives.

EXCHANGE TRANSFUSION AND HEMODIALYSIS IN *CLOSTRIDIUM PERFRINGENS* SEPSIS AFTER ILLEGAL ABORTION

S. A. Forsberg (Renstromska sjukhuset, Goteborg, Sweden), E. Klintskog, and A. Tornberg

Nord. Med. 79:151-155, (Feb. 1), 1968.

Within hours of the appearance of postabortal gas gangrene infection with hemolysis and renal failure, a patient received antibiotics and steroids, and exchange transfusion was started. The patient survived the acute septicemic phase; renal failure with anuria persisted and was treated by hemodialysis. Renal function became normal. The patient recovered completely and 15 months after the onset of illness, gave birth to a healthy child; pregnancy and delivery were normal.

RELATION OF BURKITT'S TUMOR-ASSOCIATED HERPES-TYPE VIRUS TO INFECTIOUS MONONUCLEOSIS

G. Henle, W. Henle, and V. Diehl (Children's Hospital, Philadelphia)

Proc. Nat. Acad. Sci. USA 59:94-101, (Jan.), 1968.

Patients with infectious mononucleosis (IM) regularly develop antibodies to the herpes-type virus (EBV) found in cultures derived from Burkitt's tumors or other cells of the hematopoietic system. The antibodies persist for many years and are distinct from heterophile antibodies. The epidemiology of IM and the sero-epidemiology of EBV share many features. It appears that EBV, or a close relative of it, is the cause of IM, but there is also the possibility that EBV might be involved, either directly or indirectly, in the etiology of Burkitt's lymphoma.

TREATMENT OF BACTERIAL INFECTIONS WITH HYPERBARIC OXYGEN

T. T. Irvin and G. Smith (University of Aberdeen, Aberdeen, Scotland)

Surgery 63:363-376, (Feb.), 1968.

Two patients, with a clostridial infection and the second with gangrene of the skin, were treated with intermittent hyperbaric oxygen therapy. Both patients recovered. Inhalation of hyperbaric oxygen may be of value in treatment of gas gangrene. Its use might be successfully extended to treatment of infections by microaerophilic organisms. When aerobic infections occur superficially as in burns, local application of hyperbaric oxygen may be of distinct value. In order to determine the true value of hyperbaric oxygen, further clinical and experimental studies are needed in larger groups of patients with various forms of infection.

LIDOCAINE IN MANAGEMENT OF ARRHYTHMIAS AFTER ACUTE MYOCARDIAL INFARCTION

D. E. Jewitt (Royal Postgraduate Medical School, Ducane Rd., London), Y. Kishon, and M. Thomas

Lancet 1:266-270, (Feb. 10), 1968.

The value of intravenous lidocaine (Xylocaine) in the management of arrhythmias after acute myocardial infarction was assessed. Of 27 patients with frequent ventricular extrasystoles, adequate suppression was achieved in 24 by using a continuous intravenous infusion of lidocaine, 1 to 2 mg/minute. Ventricular tachycardia was terminated in 11 patients by a single intravenous injection of 1 to 2 mg/kg body weight, without resort to DC cardioversion. Lidocaine was of little value in the management of supraventricular arrhythmias. Hemodynamic studies in eight patients showed no deleterious side-effects after intravenous lidocaine in this dosage. Lidocaine may be the anti-arrhythmic drug of choice in the management of ventricular arrhythmias after acute myocardial infarction.

REVERSIBLE "CANCER" AND THE CONTRACEPTIVE PILL

J. Graham, R. Grahan, and K. Hirabayashi (Roswell Park Memorial Institute, Buffalo, N.Y.)

Obstet. Gynec. 31:190-192, (Feb.), 1968.

A hyperplastic lesion of the endocervix histologically mimicked cancer in a woman using a contraceptive pill consisting of norethynodrel and mestranol. This is a rare complication of a hormonal contraceptive. Those who use these agents should bear it in mind; confusion with cancer could have serious consequences.

CRITICAL ILLNESSES AND DEATH ASSOCIATED WITH INTRAUTERINE DEVICES

R. B. Scott (2105 Adelbert Rd., Cleveland)

Obstet. Gynec. 31:322-327, (March), 1968.

To determine the magnitude of deaths and critical illnesses in association with the use of intrauterine devices, a questionnaire was sent to all Fellows of the American College of Obstetricians and Gynecologists in the United States, Canada, and Puerto Rico. Over 75% (6,449 of 8,506) questionnaires were completed and returned. Ten deaths were reported; in four deaths overwhelming pelvic inflammation plus sequelae seemed to be related to the insertion of intrauterine devices. Eleven and six-tenths percent of the respondents were aware of critical illness in their community in association with the use of intrauterine devices. Pelvic inflammations and their sequelae were about twice as frequent as complications from perforations. The expected yearly incidence of pelvic infection in this population group is not known. There were 15 instances of uterine perforations followed by surgery for intestinal obstruction. The "bow," closed loop-type of device, compared to other types, accounted for the majority of the perforations.

MONGOLISM, DELAYED FERTILIZATION, AND HUMAN SEXUAL BEHAVIOR

G. German (Cornell University Medical College, New York)

Nature 217:516-517, (Feb. 10), 1968.

Mongolism (Down's syndrome) is the developmental consequence of trisomy of chromosome 21. The increased incidence among offspring of mothers more than 35 years old suggests that the chromosomal nondisjunction usually occurs during female rather than male gametogenesis. The human secondary oocyte

They're just the legs off a store mannikin, but you ought to hear the reactions I get!

Hello, Fred, are you feeling kind of listless and draggy again?

suspended in metaphase has been estimated to be fertilizable for one day or less. Fertilization toward the end of this brief period often has serious embryological consequences in many species. Decreasing frequency of coitus accompanying advancing age and prolongation of marriage, predisposing to delayed fertilization, may explain the correlation of increased incidence of mongol births with advancing maternal age.

POTENTIAL MEDICAL PROBLEMS IN PERSONNEL RETURNING FROM VIETNAM

D. N. Gilbert et al. (W. L. Moore, Brooke General Hospital, Brooke Army Medical Center, Fort Sam Houston, Tex.)

Ann. Intern. Med. 68:662-678, (March), 1968.

Since the majority of individuals are now moved by air, return to the United States occurs within the incubation period of almost all communicable diseases. Upon return, most military personnel go on leave, hence often may be seen by civilian physicians. Malaria, due primarily to chloroquine-sensitive strains of *Plasmodium vivax* and chloroquine-resistant strains of *Plasmodium falciparum*, will be encountered most frequently and often mimics other diseases. Patients with diarrheal diseases, hookworm or fever of unknown origin will also be seen with some frequency. Tropical sprue, melioidosis, plague, and other forms of helminthiasis also must be considered. Other diseases to be considered include tuberculosis, leprosy, rabies, infectious hepatitis, venereal diseases, and perhaps filariasis and schistosomiasis. Today the scope of medicine in the US must include awareness of international medical problems. ◄

From *The Journal* 50 Years Ago

. . . It would seem that in a community the size of ours, there would be room for men making a specialty of obstetrics exclusively. This condition exists in cities no larger than our own, but it has been proven conclusively here that it is impossible to subsist on the revenues derived from a limited practice of this kind. Thus it falls to a man in general practice to play the obstetrical tune for his little flock with the occasional surgeon accompanyist, and it would appear that these flocks are well taken care of and satisfied, as is proven by the fact that the man who has taken the stand of an obstetrician exclusivium continues to allow his talents along other lines to become developed and active in order that he may supply the demands of his family.

A doctor to be a successful obstetrician must first be qualified by the possession of certain personal attributes which coupled with sound judgment and knowledge of the subject are absolutely essential. Vigilance and patience are, in the writer's estimation, attributes of the greatest importance. By vigilance I mean the careful watching and safeguarding of the parturient from the time she comes under observation until the end, and by the end I mean until the uterus has fully involuted. Only after a final inspection and examination eight weeks after delivery is this obligation of the accoucheur fulfilled. . . . The public is beginning to realize that it is not getting the best unless the doctor's instructions are followed to the letter, and the truth is dawning slowly though painfully that as better and more scientific medical service is being given it must be paid for proportionately . . . . Frank E. Abbett, M.D., Indianapolis, "A Plea for More Conservative Obstetrics," *JISMA*, June, 1918.

The Cancer You View

DISCUSSION

The lip is the most common site of cancer of the oral cavity. Squamous cell carcinomas predominate among lesions of the lip. A few adenocarcinomas are of mucous membrane or of minor salivary gland origin.

Exposure to solar rays and atmospheric conditions is accepted as a cause of cancer of the lip and skin cancers. Geographic areas with intense sunlight or occupations with continued exposure to the elements have an increased incidence. Sun, wind, and dust with lack of atmospheric moisture produce drying of the labial mucosa and eventually result in keratotic thickening. With these persistent stimuli to growth, malignant changes may occur.

Ulcerated lesions of the lip of more than two or three weeks duration should arouse the suspicion of cancer. The common herpes labialis, "fever blister", is more painful and heals completely with minimal treatment.

Reactive keratosis may resemble carcinoma. Often, only microscopic examination will reveal or exclude cancer in these areas.

Luetic lesions (white patches) may appear to be similar. An incidental positive serologic test for syphilis should not create needless delay before biopsy.

The appearance, tumefaction, and chronicity of a tuberculous ulceration may suggest malignancy, but is almost always concurrent with active pulmonary disease.

Tissue should be removed for biopsy with observation of the following points: a specimen should be obtained which is characteristic of the lesion and include deeper portions of the tumor; the specimen must not be taken with cautery and should be handled carefully to avoid crushing or dehydration; and if a negative biopsy report is received when there is strong clinical evidence of cancer, it is mandatory that a rebiopsy be performed.

There is some merit to the opinion that the biopsy should be performed by the individual who will treat the lesion. This avoids the difficulty which arises when subsequent healing obscures the limits of residual neoplasm after the biopsy of small carcinomas. In the surgically managed lesion, frozen section study can be utilized for confirmation of diagnosis as well as adequacy of resection.

The predominant involvement of the lower lip is related to its greater exposure. The higher incidence in men may be due to occupations which increase exposure and drying; the protection afforded by lipstick may lower the incidence in women.

Metastasis to the cervical lymph nodes from lip cancers usually occurs late or with deeply invading lesions. Central lower lip lesions will involve the submental nodes; primary lesions located to either side spread to the submaxillary nodes. Attachment of the primary lesion or nodal metastases to the mandibular periosteum with bony invasion may occur. Occasional instances of involvement of the mandibular canal via invasion of the lymphatics of the mental nerve have been reported. These are usually revealed as mandibular recurrances, although this can be suggested by pathologic findings at the time of initial excision.

Cancer of the lip is the most readily cured oral cancer. In adequately treated patients, the five-year survival rate without evidence of recurrence approaches 90%.

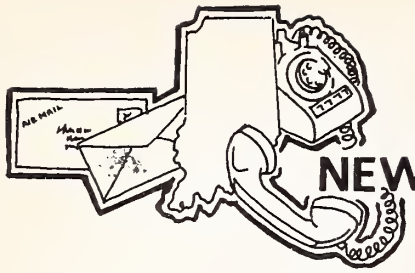
Leukoplakia or premalignant keratosis can be managed by the "lip shave" technic, accompanied by thorough microscopic examination for evidence of invasive malignancy. If present, more extensive surgical excision is required.

Radiation therapy and surgical ablation offer comparable cure rates. Surgery is preferred in the younger patient where continued exposure to causal factors is likely to occur. It is my feeling, that although the initial appearance following radiation therapy is better, the cosmetic result several years after surgical therapy is superior.

En bloc lymphadenectomy should be performed concurrently with the excision of the primary lesion when there is clinical evidence of metastasis.

The high cure rate of lip carcinoma can be maintained with continued alertness to suspect unhealing lesions. Biopsy of all keratotic lesions or suspicious ulcerations is needed to confirm the diagnosis. As a surgeon, I feel that surgical management offers some advantages, but I also recognize that equal cure rates are obtained by radiation therapy. ◄

1815 N. Capitol Ave.
Indianapolis 46202



NEWS NOTES

MEDIC ALERT FOUNDATION WORK IN EMERGENCY MEDICAL IDENTIFICATION

The Medic Alert Foundation is a nonprofit, charitable, tax-exempt organization, founded in 1956, and dedicated to educating and encouraging individuals to wear on their person identification of any medical problems which should be known in an emergency.

In addition to providing the Medic Alert emblem, the Foundation maintains a central file which contains detailed information on each of their members. The Central File accepts, on a 24 hour a day basis, collect calls from physicians and emergency room personnel and relays the full information.

The membership fee is $7.00 which includes a bracelet or necklace of stainless steel engraved with the critical medical information such as "Diabetic"—"Taking Anticoagulants", etc. The emblem also carries the wearer's Foundation serial number and the Foundation's phone number. More than 200,000 Americans now wear the emblems.

The Foundation was founded by a doctor whose daughter had a serious anaphylactic reaction as a result of a scratch test for tetanus antitoxin. The address is: Medic Alert Foundation, Turlock, California 95380, telephone 209-632-2371.

Dr. Caplin Speaks

Dr. Irvin Caplin, director of the allergy clinics of both Riley Hospital and Methodist Hospital Graduate Medical Center, was guest speaker recently at a tea sponsored by the Indianapolis Chapter of the Children's Asthma Research Institute and Hospital.

Dr. Silver is Speaker

Dr. Richard A. Silver, Indianapolis radiologist, spoke on "Progress in Cancer Treatment" at a recent meeting of the Madison County Cancer Society.

Need for Medical Evaluation In Driver Licensing Reprints Available

A new attack has been launched on the problem of providing a more adequate method of determining the fitness of applicants for driver's licenses. The spearhead of the attack is a new guide, "Determination of Need for Medical Evaluation in Driver Licensing," just developed by the AMA Committee on Medical Aspects of Automotive Safety.

This guide, aimed at non-medical licensing authorities, suggests a screening procedure to be used on all license applicants, with only those seeming to present an unwarranted risk as drivers being required to have an examination by a physician. To do such screening effectively, lay licensing authorities will have to have medical advice and guidance. The Committee on Medical Aspects of Automotive Safety suggests that state medical association committees on automotive safety work very closely with state licensing authorities and also with county medical societies.

In addition to improving licensing procedures, the AMA committee feels that this new guide will go a long way toward eliminating agitation for legislation which would require medical examinations for *all* drivers, as well as that which proposes compulsory reporting by physicians of conditions in their patients which might make driving unsafe. Both of these principles have been opposed by the medical profession for many reasons, principally that they are unworkable. In addition, the compulsory reporting proposal is felt to interfere with the confidentiality of medical records as well as with the traditional physician-patient relationship.

"Determination of Need for Medical Evaluation in Driver Licensing" was published originally in the March 4th issue of *The Journal of the American Medical Association,* and reprints were distributed to state medical associations. Individual copies may be obtained from the Committee on Medical Aspects of Automotive Safety, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Dr. Burns is Speaker

Dr. Paul E. Burns, Montpelier, was the featured speaker at a recent meeting of the Jay County Association for Mental Health. Dr. Burns has been active at both the local and the state level since the beginning of the Indiana Association for Mental Health. He was named "Indiana Physician of the Year" in 1966 for his efforts on behalf of the mentally ill.

Dr. Golper Elected

Dr. Marvin N. Golper, Kokomo radiologist, has been elected the new president of the American Cancer Society, Indiana Division.

American Heart Association Invites Research and Grant Applications

The Indiana Heart Association is calling attention to the invitation by the American Heart Association for applications for research investigators and grants.

September 15 is the deadline for submitting applications for Established Investigators, Foreign Visiting Scientists and British-American Research Fellowships. November 1 is the deadline for applications in the Grants-in-Aid category.

Application forms for investigatorships and fellowships may be obtained from the Director of Research, American Heart Association, 44 E. 23rd St., New York City 10010.

Dr. Lamb Takes Course

Dr. J. Leonard Lamb, South Bend, recently attended an intensive post-doctoral course in gynecology at Vincent Memorial Hospital in Boston.

Dr. Strecker is Speaker

Dr. William L. Strecker, Terre Haute, was guest speaker at a recent meeting of the Indiana Chapter of American Association of Inhalation Therapists at St. Anthony Hospital there.

Dr. Brown Appointed

Dr. Frederick W. Brown, Fort Wayne, has been appointed to the National Advisory Allied Health Professions Council of the National Institutes of Health. The Council will advise the Division of Allied Health Manpower on matters relating to the Allied Health Professions Personnel Training Act of 1966.

Dr. Baum Named

Dr. John R. Baum, Warsaw, was recently named "Man of the Year" by the local Chamber of Commerce. Dr. Baum has

been a physician in Warsaw for 40 years.

Dr. Hickam Subject of Story

Dr. John B. Hickam, chairman of the department of medicine at Indiana University Medical School, was the cover story subject on a recent issue of *Modern Medicine.*

Dr. Goddard Resigns

Dr. James L. Goddard, the controversial commissioner of the Food and Drug Administration for 28 months, resigned in June to take a position as corporate vice president for health sciences in the newly organized EDP Technology, Inc.

EDP is a Washington based company which specializes in urban systems planning. Dr. Goddard will be in charge of their Atlanta office. Dr. Goddard also resigned his commission in the U. S. Public Health Service.

Dr. Boling Gives Talk

Dr. Richard C. Boling, Elkhart ophthalmologist, spoke at a recent meeting of the North Central Optometric Society. His topic was "Retinal Vascular Changes", with slide illustrations.

Dr. Schuster Named

Dr. Dwight W. Schuster, Indianapolis, has been named chairman of the physicians division to direct volunteer activities of the United Fund.

American Physician Will Receive $10,000 Sheen Award

The AMA will participate in the annual selection of an American physician to receive the $10,000 Dr. Rodman E. Sheen and Thomas G. Sheen Award which was announced recently.

The award is set up by the will of Thomas Sheen to honor his brother, Rodman, who was a doctor in Atlantic City. He was one of the pioneer radiologists and died in 1937 as a result of a tumor complicated by an old injury produced by an exploding x-ray tube.

The last of the primary beneficiaries of the will died this year and the residual portion of the estate will support the award which will be given each year to the "nation's outstanding medical doctor."

New Mead Johnson President

William M. Govier, M.D., has been appointed as president of the Mead Johnson Research Center. He will have responsibility for world-wide research and domestic product development. He was formerly associated with Warner-Lambert Research Institute and has also been vice-president of Warner-Chilcott Laboratories.

Dr. Wiseheart Receives Award

Dr. Robert H. Wiseheart, Lebanon, recently received an award from the Lebanon Kiwanis Club for outstanding service to the community and to his church.

Doctors Attend Meeting

Drs. William E. Schoolfield and Phillip T. Hodgin, Orleans, attended a four-day annual scientific assembly of the American Academy of General Practice in Dallas. They heard 26 guest speakers discuss up-to-the-minute health care topics and had the opportunity to visit more than 125 scientific and 250 technical exhibits.

Bloomington Girl Wins in AAPS Prize Essay Contest

Elaine E. Mobley of Bloomington has been awarded a prize in the AAPS Prize Essay Contest. Miss Mobley, competing on a national scale, won the 14th prize in writing on "The Advantages of the American Free Enterprise System."

AAPS announces their 1969 contest, the 23rd annual national contest for high school students. County medical societies are invited by AAPS to sponsor the 1969 Essay Contest for high school students.

VA Establishes "Distinguished Physician" Position for VA Doctors

The Veterans Administration has established the position of "Distinguished Physician" and has chosen Dr. William B. Castle, Professor of Medicine at Harvard University, as its first appointee.

The post was designed to bring physicians to the VA "who have made very significant contributions to medical science and have attained exceptional professional stature over long and distinguished careers."

Dr. Castle, beginning in August, will be stationed at the VA Hospital in West Roxbury, Massachusetts. Each Distinguished Physician, while being located at a particular VA Hospital, will be available on a VA-wide basis as a consultant, lecturer, or in other teaching capacities.

Dr. Craig is Guest Speaker

Dr. Harry L. Craig, Huntingburg, was the guest speaker at a recent meeting of the Registered Nurses of District 18 of

OVER 100 YEARS
of service in the prosthetics field

Hanger Prosthetics

The year 1961 marked one hundred years of service in the field of prosthetics for the Hanger Organization. Over these one hundred years the name Hanger has become synonymous with prosthetic appliances.

J. E. Hanger, who in 1861, founded the Hanger Organization

• There are over 50,000 wearers of Hanger Prostheses — more than any other make • Complete line of arm and leg prostheses for all types of amputations • Constantly improved through research • The Hanger Organization offers the services of Certified Prosthetists • Advanced college courses given Hanger Prosthetists • Nearly 40 offices in principal cities.

Moy we put our yeors of experience to work for you?

Hanger Prosthetics — Centennial Hanger Anniversary

1332 N. Illinois St., Indianapolis, Ind. 46202
3108 Burnet Avenue, Cincinnati, Ohio 45229
446 W. Pontiac St., Fort Wayne, Ind. 46807
416 N. Main St., Evansville, Ind. 47711

the Indiana State Nurses Association. Dr. Craig spoke on his experiences during his stay in Vietnam.

Dr. Koss is Speaker

Dr. K. William Koss, Muncie, chairman of the medical advisory committee of the Central Indiana Cystic Fibrosis Association, recently was guest speaker for a meeting of Delaware-Blackford Medical Assistants.

Dr. Butler Named

Dr. Henry L. Butler, Chief of Staff at the Ft. Wayne VA Hospital since 1962, has been named Director of the Beckley, W. Va., VA Hospital.

Dr. Harvey is Instructor

Dr. Emerson C. Harvey, Jr., Kokomo, has been instructing a conditioning class for men and two slim-trim classes for women at the YMCA.

Dr. How is Speaker

Dr. Louis E. How, South Bend, recently spoke to the St. Joseph County Association of Medical Assistants.

AMPAC Establishes Fellowship In Business-Government Relations

The American Medical Political Action Committee, AMPAC, has established a Fellowship in Business-Government Relations at The American University's School of Business Administration.

AMPAC will provide annually a Graduate Fellowship of $4,500, plus a $500 grant to the Business-Government Relations Program. AMPAC now joins Whirlpool which presently offers two similar Fellowships. Other contributors to this growing program are The American Oil Foundation, Corning Glass Works Foundation, The General Electric Foundation, Hill & Knowlton, Inc., Hughes Aircraft Company, PPG Industries Foundation, Sears, Roebuck and Company, and Standard Oil (Indiana) Foundation, Inc.

In making the grant, Dr. Blair J. Henningsgaard, the Committee Chairman, said, "The decision of the AMPAC Board of Directors to establish a Fellowship at The American University was based upon our conviction that the relationship existing between government on the one hand, and business and the professions on the other, are becoming more complex each year."

ESCORT YOURSELF . . .

to Home Lawn Mineral Springs for a few days health vacation —the mineral baths and excellent meals in an atmosphere of serenity will leave your cares behind and play golf on a beautiful course.

HOME LAWN MINERAL SPRINGS

Martinsville, Indiana

M. C. Pitkin, M.D.
Medical Director

J. W. Gibbs, M.D.
Associate
Medical Director

Dr. Green Gives Talk

Dr. Frank H. Green, Jr., Rushville, secretary of the Rush County Board of Health, gave a talk on the new health program in the county at a recent meeting of the Woman's Council.

Dr. Zeier Returns

Dr. Francis G. Zeier, Evansville, recently returned from a trip to Cartagena, Colombia, on the S.S. HOPE. Dr. Zeier has been on several HOPE trips before, and would like to go next year when the ship sends medical aid to Ceylon.

American Academy of General Practice Publishes New Guide

A new practice management guide has been published by the American Academy of General Practice. The 105-page manual is designed to provide the general or family physician with professional help in handling the business aspects of medical practice. Community and professional relationships are also covered.

It is recommended both for the physician who is establishing his first practice and for the physician who wants to evaluate the efficiency of his present office. The manual is being made available to all Academy members.

It will also be made available free of charge on request to medical students, interns, residents and medical school and hospital libraries. Others may purchase it at $1.00 per copy by writing the Academy at Volker Blvd. and Brookside, Kansas City, Missouri 64112.

Dr. Rudolph Appointed

Dr. Rosser A. Rudolph, Jr., Geneva, has been appointed to the consulting staff of Blackford County Hospital. Dr. Rudolph was also appointed director of the laboratory.

Dr. Braunlin Lectures

Dr. Robert J. Braulin, Fort Wayne, recently presented a lecture at the Davis Clinic building on "Serious Otitis Media and Cholesteatoma Formation."

Summer Camps Announced For Handicapped Children

Summer camps for children of all faiths who are handicapped (deaf, blind or physically handicapped) are maintained by the Indiana Baptist Convention at Indian Creek Baptist Camp near Bedford and at Tippecanoe Baptist Camp at North Webster. Supervision is by capable adults.

The camp fee is $24.00 for six days. Write the Indiana Baptist Convention, Camps for Children with Special Needs, 1350 N. Delaware St., Indianapolis 46202. ◄

Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION ANNUAL CONVENTION
Date Dec. 1-4, 1968
Place Miami Beach, Fla.

NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville

INDIANA PSYCHIATRIC SOCIETY
Date Second Wednesday of the month October through May, excluding December
Place The Athenaeum, Indianapolis

AMERICAN COLLEGE OF SURGEONS INDIANA CHAPTER
Date April 17-19, 1969
Place Purdue University, West Lafayette

BONE AND JOINT CLUB
Date October 30, 1968
Place Athenaeum, Indianapolis

INDIANA ACADEMY OF GENERAL PRACTICE
Date April 15-17, 1969
Place Evansville

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
Date April 30-May 1, 1969
Place Imperial House, Columbus

INDIANA CHAPTER OF AMERICAN ACADEMY OF PEDIATRICS
Date May 14-15, 1969
Place Stouffer Inn, Indianapolis

INDIANA DENTAL ASSOCIATION
Date May 10-14, 1969
Place Murat Temple and Essex House Motel, Indianapolis

INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY
Date October 9, 1968
Place Marott Hotel, Indianapolis

INDIANA PUBLIC HEALTH ASSOCIATION, INC.
Date April 22-24, 1969
Place Stouffer Inn, Indianapolis

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 15-18, 1968
Place Fort Wayne

INDIANA ROENTGEN SOCIETY
Date May 4, 1969
Place Holiday Inn, Indianapolis

INDIANA SOCIETY OF ANESTHESIOLOGISTS
Date May 24, 1969
Place Marott Hotel, Indianapolis

INDIANA STATE LICENSED PRACTICAL NURSES' ASSOCIATION, INC.
Date May 5-9, 1969
Place Robert Lee Motel, New Albany

INDIANA STATE NURSES ASSOCIATION
Date October 16-18, 1969
Place Civic Auditorium, Evansville

Postgraduate Programs Listed By University of California at Berkeley

The Division of Maternal and Child Health of the University of California School of Public Health at Berkeley announces postgraduate programs for pediatricians, obstetricians and other interested physicians. The programs all lead to the degree of Master of Public Health.

The programs on Maternal and Child Health, Family Planning and School Health are 9 months in duration. The Multiply Handicapped and Mentally Retarded Child is a 21-month program. There is a three-year academic and residency program on comprehensive health planning.

Applications are now being accepted for entrance in July or September, 1969. For information write Helen M. Wallace, M.D., School of Public Health, University of California, Berkeley, California 94720.

University of Colorado Offers Postgraduate Pediatrics Course

The University of Colorado will conduct a postgraduate course in pediatrics on August 5 to 8 at Aspen High School in Aspen, Colorado.

The program will be presented by both the Colorado faculty and guest speakers. Registration and tuition fees are $80. For full particulars write Postgraduate Medical Education, 4200 E. Ninth Ave., Denver 80220.

Another postgraduate course at the University of Colorado School of Medicine includes Dermatology—August 1 to 3 at Aspen, and the 15th Western Cardiac Conference—October 9 to 11 at Denver. Write the School of Medicine at 4200 E. Ninth Ave., Denver, 80220 for full particulars on the dermatology course, and the Colorado Heart Association, 1375 Delaware St., Denver 80204 for the Cardiac Conference.

University of Wisconsin Lists Workshop for August 22-24

The University of Wisconsin will conduct a 2½-day workshop on the subject "Exercise as a Therapeutic Tool in Coronary Heart Disease" on August 22 to 24.

For further information write Dr. Thomas C. Meyer, Room 302, 333 N. Randall Ave., Madison, Wisconsin 53706.

Postgraduate Course in Laryngology, Bronchoesophagology

The Department of Otolaryngology of the Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, will conduct a postgraduate course in Laryngology and Bronchoesophagology from September 23 through October 4. This course is limited to fifteen physicians and will be under the direction of Paul H. Holinger, M.D. It will be held largely at the new Illinois Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, and will include visits to a number of Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in brochoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants will please write directly to the Department of Otolaryngology, College of Medicine, University of Illinois at the Medical Center, Postoffice Box 6998, Chicago, Illinois 60680.

AMA Sponsors 10th Conference On The Medical Aspects of Sports

The Tenth National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association under the auspices of its Committee on the Medical Aspects of Sports, will be held in Miami Beach, Florida, at the Hotel Deauville on December 1. The Conference is held annually in conjunction with and on the first day of the Clinical Convention of the American Medical Association.

The conference is open to key nonmedical athletic personnel as well as interested physicians. Those who would like to receive further information concerning the conference should address the Committee on the Medical Aspects of Sports, American Medical Association, 535 N. Dearborn St., Chicago, Illinois 60610.

ISMA Physicians Invited to Big Sky Medical Pow Wow

ISMA members are invited to combine a high quality postgraduate seminar with an equally high quality vacation and sightseeing trip by attending the Big Sky Medical Pow Wow at Great Falls, Montana on August 15, 16 and 17.

It is sponsored by the Cascade County Medical Society and is

approved for 11½ hours of credit by the AAGP. The registration fee is $10.00. Write Dr. Robert E. Wynia, 203 20th St. So., Great Falls 59401.

"Difficult Problems in Pediatrics, Pediatrc Surgery" Course Offered

The Johns Hopkins Hospital will conduct a two-day postgraduate symposium on "Difficult Problems in Pediatrics and Pediatric Surgery" on October 11 and 12.

The registration fee, which includes Friday luncheon and dinner, is $50.00. Write Dr. J. Alex Haller, Jr., The Johns Hopkins Hospital, Baltimore 21205.

Tenth International Congress on Diseases of the Chest in October

The Tenth International Congress on Diseases of the Chest will be held at the Washington Hilton Hotel, Washington, D.C., October 4 to 8.

One hundred forty-four scientific papers on all aspects of cardiovascular and pulmonary diseases will be presented. The American College of Chest Physicians will be the host organization. For full information and registration forms write the College at 112 E. Chestnut St., Chicago 60611.

"Upper Gastrointestinal Tract Disease" Subject of Two-Day Course

"Upper Gastrointestinal Tract Disease" will be the subject of a two-day postgraduate course to be conducted by the Cleveland Clinic on November 6 and 7. Write the Education Secretary at 2020 E. 93rd St., Cleveland 44106 for full particulars.

International College of Surgeons To Conduct Joint Meeting in Hawaii

The International College of Surgeons will conduct a joint meeting of its two Western Hemisphere Federations in Honolulu from September 28 to October 3.

A distinguished group of international authorities will talk. The fee for non-members is $40. For full information and registration write the College at 1516 N. Lake Shore Drive, Chicago 60610.

International College of Surgeons 16th Biennial Congress in Tokyo

The International College of Surgeons will hold its Sixteenth Biennial International Congress in Tokyo beginning on October 6.

The congress is open to doctors from all over the world who wish to attend. The registration fee is $80. Full details may be obtained from the College at 1516 N. Lake Shore Drive, Chicago 60610.

Second National Congress on Medical Ethics Will be October 5-6

The Second National Congress on Medical Ethics will be conducted under the auspices of the AMA at the Drake Hotel in Chicago on October 5 and 6.

The program this year will be devoted to practical consideration and application of ethical principles in everyday practice. Attendance will be limited. Early registration is encouraged. Write the AMA Judicial Council, 535 N. Dearborn, Chicago 60610.

Annual Otolaryngologic Assembly To be October 12 through 18, 1968

The annual Otolaryngologic Assembly of 1968 will be held October 12 through 18, in the Illinois Eye and Ear Infirmary at the Medical Center, Chicago. The Department of Otolaryngology of the College of Medicine of the University of Illinois offers a condensed postgraduate basic and clinical program for practicing otolaryngologists under the direction of Dr. Emanuel M. Skolnik. It is designed to bring to specialists current information in medical and surgical otorhinolaryngology.

A separate, but correlated course entitled "Head and Neck Radiology Conference" under the guidance of Doctor Galdino E. Valvassori, will be conducted by the department of radiology for two full days just preceding the assembly, Thursday and Friday, October 10 and 11, 1968.

Interested physicians should direct communications to the mailing address: Department of Otolaryngology, P. O. Box 6998, Chicago, Illinois 60680.

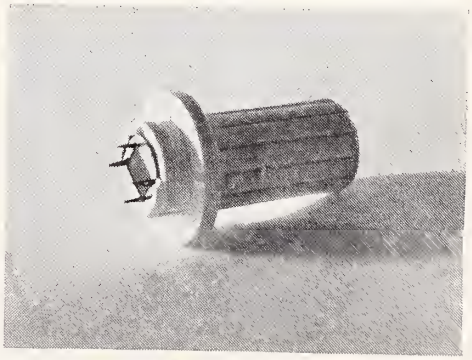
Annual Postgraduate Course in Gastroenterology to be in Boston

The Annual Postgraduate Course in Gastroenterology will be conducted by the American College of Gastroenterology in the Statler Hilton Hotel in Boston on October 21 and November 1 and 2.

The faculty will be from the medical schools in Boston. Advances in diagnosis and treatment, from medical and surgical viewpoints, will be the theme of the course. Write the College at 33 W. 60th St., New York City 10023. ◄

To fight TB- find it first!

Make tuberculin testing routine with every physical examination.



TUBERCULIN,TINE TEST (Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

Lederle

330–8/6135

County, District News

First District

The First District Medical Society met May 23 in Evansville with 125 members and guests present. Drs. Donald R. Taylor and G. O. Larson were guests. Elections resulted in Dr. Gilbert Wilhelmus being re-elected councilor and Dr. Eugene Austin elected alternate councilor. Dr. Fred Smith, Tell City, was elected secretary-treasurer.

Second District

May 23 was also the date chosen by the Second District Medical Society for their annual meeting. Dr. J. S. Brown was re-elected secretary, his 46th year in this position. Dr. Betty Dukes was elected to succeed herself as alternate councilor and Dr. Joe Dukes was elected to succeed himself as Blue Shield representative.

Third District

Officers of the Third District Medical Society for the coming year will be Drs. Daniel H. Cannon, New Albany, president and Elmer L. Wallace, New Albany, secretary. Both were re-elected at the meeting held May 15th in New Albany. Dr. John Paris was re-elected Blue Shield representative and Dr. Wallace was re-elected alternate councilor.

Fourth District

The Fourth District Medical Society met May 15 to re-elect Drs. Bill E. Freeland, Batesville, president and William J. Warn, Milan, secretary-treasurer. Dr. Robert Reid, Columbus, was re-elected councilor and Dr. Robert Acher, Greensburg, vice-president.

Sixth District

Dr. Stephen Smith, Knightstown is the new president and Dr. David Wynegar, Richmond, the new secretary-treasurer of the Sixth District Medical Society. Vice-president will be Dr. Perry Seal, Brookville and Blue Shield representative will be Dr. Frank Green, Rushville.

Seventh District

New officers of the Seventh District Medical Society are: Drs. John O. Butler, president; M. O. Scamahorn, vice-president; D. E. Stephens, secretary-treasurer and James Gosman, councilor. The society met May 15 at Indianapolis.

Eighth District

The Eighth District Medical Society met June 5 in Anderson. Speaker for the event was M. Stanton Evans, editor of *The Indianapolis News*, who spoke on the "Future of Conservatism." Elections resulted in the following new officers: Drs. F. E. Stout, Muncie, president and Richard N. Philbert, Muncie, secretary-treasurer. The next meeting will be June 4, 1969, at Muncie.

Ninth District

The Ninth District Medical Society met May 16 at Monticello. The next meeting will be May 22, 1969, at Lafayette and the new officers will be the 1969 officers of Tippecanoe County. Dr. Lindley Wagner, Lafayette, was elected alternate councilor.

Tenth District

The Tenth District Medical Society met May 1 in Whiting to hear Dr. Otis R. Bowen, Bremen, discuss the state's major legislative problems. Election of officers will be at the fall meeting of the society.

Twelfth District

The Twelfth District Medical Society met May 15 in Angola. New officers of the district are: Drs. Kenneth Isenogle, Fort Wayne, president; August L. Fipp, Rome City, vice president and John J. Hartman, Angola, secretary-treasurer. Dr. Frederic L. Schoen, Fort Wayne, was re-elected alternate councilor. The next meeting will be May 21, 1969, at Fort Wayne.

Adams

Dr. Donald Taylor, Muncie, spoke on Public Law 98-749 at the May 14 meeting of the Adams County Medical Society.

Allen

New officers of the Allen County (Fort Wayne) Medical Society are: Drs. Frederic L. Schoen, president; Maurice E. Glock, vice-president; Eugene E. Schmidt, secretary and Robert J. Voorhees, treasurer.

Bartholomew-Brown

Dr. Harley P. Palmer, Franklin, spoke on "Aspects of Forensic Pathology" at the April 10 meeting at the Bartholomew-Brown County Medical Society. Twenty-seven members attended.

Boone

Officers of the Boone County Medical Society for the coming year are: Drs. James McAfee, president; Thornton D. Perkins, vice-president and Kathryn A. Jackson, secretary-treasurer.

Daviess-Martin

Dr. Joe Dukes, Dugger, spoke on the regional planning program at the April 15 meeting of the Daviess-Martin County Medical Society.

Dearborn-Ohio

Field Secretary Robert Amick reported on the Comprehensive Health Care Planning committees at the May 2 meeting of the Dearborn-Ohio County Medical Society.

Elkhart

Dr. Lichtenstein, Professor of Surgery at Northwestern University, spoke on "Perennial Problems in Surgery of the Biliary Passages" at the April 4 meeting of the Elkhart County Medical Society.

Henry

Speaker at the April 18 meeting of the Henry County Medical Society was Dr. William Elliott, Indianapolis. His topic was "Coronary Artery Disease and Cineangiography."

Howard

Dr. George Lukemeyer, Indianapolis, spoke on "The Regional Medical Plan" at the May 7 meeting of the Howard County Medical Society. Thirty-seven members attended.

Knox

Speaker at the April 30 meeting of the Knox County Medical Society was Dr. Bernard Baltes who spoke on "Recognizing Depression in General Practice."

Miami

Dr. Lowell Hillis, Logansport, spoke on "Emergency Medical Plans" at the May 14 meeting of the Miami County Medical Society.

Montgomery

"Comprehensive Health Care Planning" was the subject of Dr. Peter R. Petrich when he spoke at the May 23 meeting of the Montgomery County Medical Society.

Putnam

Dr. Robert Yoho spoke on "Community Health Planning" at the April 12 meeting of the Putnam County Medical Society.

St. Joseph

Dr. Jacob Rosenwasser, Mishawaka is the new president; Dr. R. H. Denham, South Bend, the new president-elect and Dr. Louis F. Sandock, South Bend, the new secretary-treasurer of the St. Joseph County Medical Society.

Vanderburgh

New officers of the Vanderburgh County Medical Society are: Drs. Ralph Carlson, president; R. Case Hammond, president-elect; Raymond Nicholson, vice-president and Bernard B. Rosenblatt, treasurer.

Wabash

Dr. James Harshman spoke on Comprehensive Health Care Planning at the May 13 meeting of the Wabash County Medical Society. ◄

Deaths

Kenneth D. Ayres, M.D.

Dr. Kenneth D. Ayres, 70, a retired surgeon who practiced in Anderson for 32 years, died May 17. Dr. Ayres was graduated from the I.U. School of Medicine in 1925, was a veteran of World War 1 and a former member of the Madison County Medical Society.

Anthony G. Benages, M.D.

Dr. Anthony D. Benages, who had served as radiologist at Memorial Hospital, Jasper, from the fall of 1962 until recently, died April 19 at the age of 51.

A member of the Dubois County Medical Society, Dr. Benages resigned recently preparatory to practicing and teaching at Indianapolis. He was graduated from the University of Havana in 1947 and practiced at Terre Haute before going to Jasper.

C. Toney Dutchess, M.D.

Dr. C. Toney Dutchess, 63, Galveston physician, died May 2 at a hospital in Kokomo.

Dr. Dutchess, a physician at Galveston since 1933, was graduated from the Detroit College of Medicine and Surgery in 1932. He was on the staffs of St. Joseph and Howard Community Hospitals in Kokomo and St. Joseph and Memorial Hospitals at Logansport. Dr. Dutchess was a member of the Cass County Medical Society.

James F. Harrington, M.D.

Dr. James F. Harrington, Logansport physician and surgeon for over 10 years, died April 22 at Indianapolis. He was 46.

Graduated from St. Louis University School of Medicine in 1945, Dr. Harrington set up practice in North Dakota after serving in the army and his residency. He went to Logansport in 1957. A veteran of World War II, he was a member of the Cass County Medical Society.

Lloyd M. Headley, M.D.

Dr. Lloyd M. Headley, 60-year-old Lebanon physician and member of the Boone County Council, died April 7 at his home.

Dr. Headley, a native of Dugger, was a graduate of the I.U. School of Medicine in 1939. He served as a flight surgeon in World War II and as Boone County Health Officer for more than 16 years. He was past president of the Boone County Medical Society and former chief of staff at Witham Memorial Hospital. He retired in 1966.

Harry W. Helman, M.D.

Dr. Harry W. Helman, long-time South Bend surgeon, died May 2 at the age of 85.

Graduated from the I.U. School of Medicine in 1913, Dr. Helman had practiced in South Bend since 1914. He lived at Rolling Prairie and had been a school teacher at one time. He served with the Army Medical Corps during World War I, was a Senior Member of ISMA, a member of the 50-Year Club and the St. Joseph County Medical Society.

R. Wynn S. Owen, M.D.

Dr. R. Wynn S. Owen, 73, former Indianapolis physician, died April 9 at St. Petersburgh, Fla. He was a retired physician and surgeon, a former associate professor of surgery at the I.U. School of Medicine and a former member of the Marion County Medical Society.

James F. Reilly, M.D.

Dr. James F. Reilly, 59-year-old Vincennes physician, died May 9 at Veterans Hospital in Indianapolis.

Graduated from the I.U. School of Medicine in 1932, Dr. Reilly practiced in Vincennes until entering the service in World War II. He returned to Vincennes in 1946 and practiced there until ill health forced him to retire. He was a member of the Knox County Medical Society.

Francis E. Sarver, M.D.

Dr. Francis E. Sarver, Fort Wayne surgeon, died suddenly at his home May 27. He was 52.

A native of Minnesota, Dr. Sarver had practiced in Fort Wayne 18 years. He was a veteran of World War II and a member of the Fort Wayne (Allen) County Medical Society.

Arthur R. Savage, M.D.

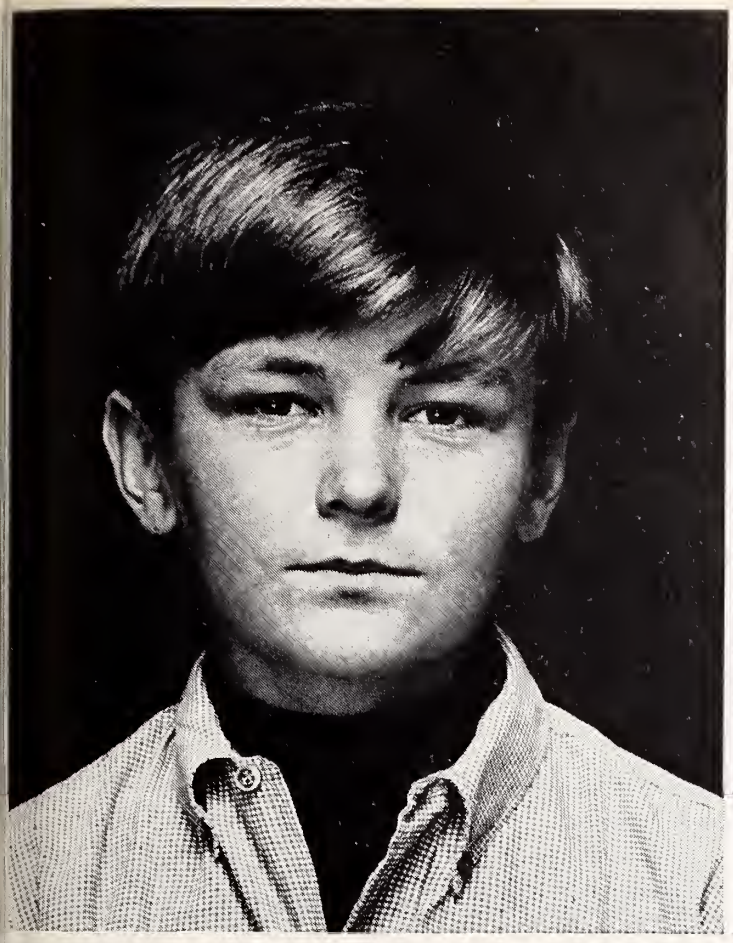
Dr. Arthur R. Savage, 59, Fort Wayne physician for more than 30 years, died May 2 while visiting in Sun Valley, Ariz.

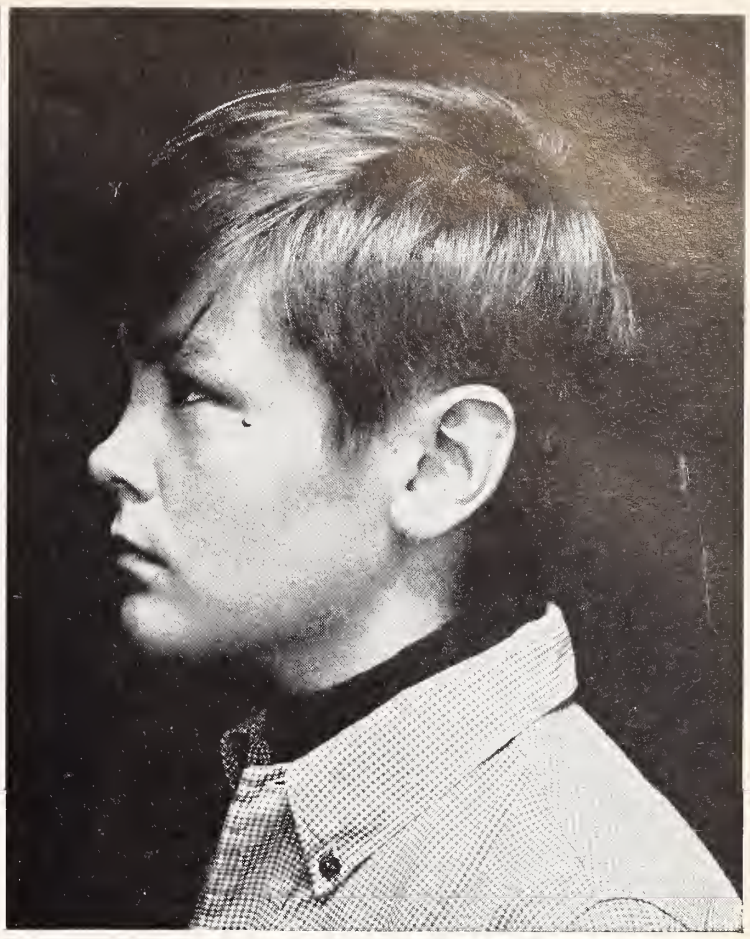
Born in LaPorte, Dr. Savage was president of the board of managers of Irene Byron Hospital and on the staff of St. Joseph's Hospital. He was graduated from the I.U. School of Medicine in 1932 and served in World War II as a captain in the Army Medical Corps. Dr. Savage was a member of the Fort Wayne (Allen) County Medical Society. ◄

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT — May, 1968

Disease	May 1968	April 1968	March 1968	May 1967	May 1966
Animal Bites	1088	959	755	955	1135
Chickenpox	482	491	667	274	344
Conjunctivitis	116	129	133	81	140
Diphtheria	0	0	0	0	1
Dysentery, Unspecified	12	82	120	21	33
Gonorrhea	465	427	579	371	303
Impetigo	62	67	99	54	65
Infectious Hepatitis	54	31	47	52	30
Infectious Mononucleosis	221	101	153	64	52
Influenza	444	680	1719	277	869
Measles					
Rubeola	143	80	150	129	1243
Rubella	203	133	103	87	438
Meningitis, Meningococcal	2	1	6	6	16
Meningitis, Other	6	1	9	5	5
Mumps	701	655	822	665	250
Pertussis (Whooping Cough)	33	41	16	20	18
Pneumonia	166	185	308	143	607
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	629	826	1185	417	606
Syphilis					
Primary & Secondary	38	45	22	9	14
All Other Syphilis	124	97	142	100	95
Tinea Capitis	6	10	17	2	4
Tuberculosis (Active)	89	68	98	77	76





How to turn a 14-year-old boy into a hardened criminal.

Just forget your keys in your car one day.

Tempt some fourteen-year-old boy into going for a joyride.

Oh, he could be a good kid — just weak.

And taking your car might be the first time he's ever broken the law.

But the minute he hops behind that wheel and turns the key, his life may be ruined.

He'll drive around for a few hours, endangering the life of every man, woman and child who crosses his path.

He might be caught the very first time he takes a car. Or if he's not caught by the police he'll leave your car somewhere and decide to do it again, and again, until the day he does get caught.

Teen-agers steal more than 1,000 cars every day.

The U. S. Department of Justice and your state and local law-enforcement agencies are concerned.

They know that taking a car for a joyride is just the first step.

Our prisons are filled with men who started out this way. They went on to become thieves, muggers, and even killers.

You can do something to help solve this terrible problem.

Whenever you get out of your car, even for a second, take your keys. Lock your car.

Every time you do this you may keep a good boy from going bad.

ADVERTISING COUNCIL

Don't help a good boy go bad. Lock your car. Take your keys.

Association News

EXECUTIVE COMMITTEE

April 7, 1968

Present: Ralph V. Everly, M.D., chairman; Burton E. Kintner, M.D., G. O. Larson, M.D., P. J. V. Corcoran, M.D., Lowell Steen, M.D., Lester H. Hoyt, M. D., M. O. Scamahorn, M.D.

Frank B. Ramsey, M.D., editor of *The Journal*. Robert E. Robinson, attorney; Kenneth W. Bush, administrative assistant; James A. Waggener, executive secretary.

Membership Report:

Full dues paying	3,773
Interns and residents	85
Full dues paying as of March 31, 1967	3,670
Interns and residents as of March 31, 1967	90

Headquarters Office

The secretary presented a renewal of the employees Blue Cross-Blue Shield coverage. On motion of Drs. Steen and Corcoran, the secretary was instructed to obtain 90 day coverage for nervous and mental diseases and then sign the contract.

Treasurer's Office

Dr. Lester Hoyt presented the report of the fund balances and investments. On motion of Drs. Hoyt and Steen, the report was adopted.

A recommendation was made that $25,000 of our current funds be invested in mutual funds. The motion was adopted by a poll vote, which was unanimous.

Unfinished Business

The Lake County resolution No. 67-2 for creating a Section on Directors of Medical Education, together with the opinion of the attorney, was referred by consent to the Commission on Constitution and Bylaws for implementation.

On motion of Drs. Corcoran and Larson, the secretary was instructed to prepare the letter to all the AMA delegates and alternates requesting their support of Dr. Frank Land's re-election to the Council on Medical Education.

Organization Matters

An exchange of correspondence between the state office and the Director of the Department of Ohio Welfare was read for the information of the committee.

A letter addressed to the State Department of Public Welfare concerning methods of handling members of the association who were found guilty of discrimination in handling welfare cases was approved for mailing on motion of Drs. Corcoran and Steen.

A letter and a newspaper article submitted by Dr. Corcoran were taken as a matter of information.

The action of the AMA Board of Trustees was reviewed for the information of the committee.

A letter from Dr. Hudson of the AMA regarding decision on Indiana's resolution No. 14 was read for the information of the committee.

The minutes of the Advisory Committee for Medical Assistance for the Aged were reviewed for the information of the committee.

Minutes of the members meeting of Blue Shield were reviewed for the information of the committee.

Correspondence between Blue Shield and Doctor Fox was reviewed and on motion of Dr. Steen, taken by consent, this matter was referred to the Council.

A letter from Ball State University stating that they were unable to procure Dr. Louria as a speaker for their seminar on drug abuse was read in which they requested the right to use the association's contribution to procure another speaker. The request was approved by consent.

The request of Dr. Dryden of Marion County General Hospital for use of the mailing list for distributing a letter to the Indiana members was approved on motion of Drs. Hoyt and Scamahorn.

A resolution adopted in 1966 concerning the members on the board of directors of Blue Shield was read and the secretary was instructed to check the actions of the House of Delegates concerning the implementation of this resolution to limit the terms of board members.

The appearance of Dr. Philip R. Lee at the I.U. School of Medicine was called to the attention of the committee.

A letter from Dr. Howard Marvel of Lafayette was reviewed for the information of the committee.

Copies of a bulletin from the Joint Commission on Accreditation of Hospitals were distributed to members of the committee for their information.

A memo from the AMA concerning submission of resolutions for the annual meeting in San Francisco was read for the information of the committee.

Actions taken at the meeting of the New York Medical Society and the American College of Radiologists were reviewed for the information of the committee.

A resolution from the Omaha Douglas County Medical Society was read and on motion of Drs. Larson and Hoyt, this resolution is to be referred to the Indiana delegation.

By consent, the secretary was instructed to write the AMA Board of Trustees and see what is being done about Indiana's resolution on unwarranted attacks on the medical profession.

A telegram from the California Medical Association was read for the information of the committee.

Annual Convention, Fort Wayne, October 15-18, 1968

The request of the First Equity Life Insurance Company of Anderson, Indiana to be an exhibitor at the annual meeting, was approved by consent.

AMA Meeting

Several letters concerning the candidacy of Dr. Lester Bibler for re-election to the board of trustees and announcements of other states concerning candidates they were proposing to run for the board were reviewed.

Congressional Dinner

Letters of appreciation from several members of the Indiana delegation in Congress regarding the annual meeting with them were read for the information of the committee.

New Business

Upon motion of Drs. Steen and Kintner, the secretary was instructed to invite the AMA delegates to attend the next Executive Committee meeting on May 18th. Any decisions concerning the support of trustee candidates to be left solely to the AMA delegation.

Upon motion of Drs. Steen and Corcoran, the Executive Committee is to recommend to the Council that any program in which the ISMA is a sponsor, that at least one or three members of the Council attend as official observers.

It was further moved that the discussion concerning Junior-Senior Day, a transcript in its entirety, be sent to Dr. Middleton and the councilors.

Dr. Corcoran recommended that the Executive Committee should discuss areas dealing with mental health, student health services and future problems with respect to fees of physicians at the July meeting.

Future Meetings

Annual meeting of the Indiana State Chamber of Commerce, April 19-21. No representative will be sent inasmuch as Dr. Don Wood as a member of the board would be in attendance.

The 5th AMA Conference on Environmental Health Problems to be held in Chicago on April 29-30. On motion of Drs.

Steen and Larson, Doctor Donato is to be requested to represent the association.

Letters of invitation from the Wisconsin and Illinois State Medical Societies, requesting the attendance of the executive secretary, were approved by consent.

The AMA Regional Conference in Chicago on May 28th. By consent it was agreed that the president; president-elect; chairman of the Council and the executive secretary would attend.

There being no further business the committee adjourned to meet again at 2:00 p.m. on May 18th in the headquarters building. The AMA delegates and alternates are to be requested to appear at 4:00 p.m. on that date. ◄

THE COUNCIL

March 8, 1968

The Council of the Indiana State Medical Association convened at 8:30 a.m., Friday, March 8, in the Sheraton Park Hotel, Washington, D.C., with Dr. Lowell H. Steen, the chairman, presiding.

Roll call showed the following present:

Councilors:

First District—Gilbert M. Wilhelmus, Evansville
Second District—Joe Dukes, Dugger
Third District—Donald M. Kerr, Bedford
Fourth District—Robert M. Reid, Columbus
Fifth District—Wilbert McIntosh, Riley
Sixth District—Not represented
Seventh District—Albert M. Donato, Indianapolis
Eighth District—Donald R. Taylor, Muncie
Ninth District—Not represented
Tenth District—Lowell H. Steen, Whiting
Eleventh District—Lowell J. Hillis, Logansport
Twelfth District—William R. Clark, Fort Wayne
Thirteenth District—Not represented

Officers:

G. O. Larson, LaPorte, president
Patriek J. V. Corcoran, Evansville, president-elect
Lester H. Hoyt, Indianapolis, treasurer
Malcolm O. Scamahorn, Pittsboro, assistant treasurer

Executive Committee:

Ralph V. Everly, Indianapolis, chairman
Burton E. Kintner, Elkhart, member

Guests:

Don E. Wood, Indianapolis, chairman, IMPAC Board
Kenneth O. Neumann, member, IMPAC Board
Joe M. Black, member, IMPAC Board
Blair J. Henningsgaard, chairman, AMPAC Board
Mr. Joe Miller, executive director, AMPAC
Mrs. Lee Ann Elliott, AMPAC staff
Mr. James Imboden, AMPAC field representative

Staff:

Robert J. Amick, field secretary
Howard Grindstaff, field secretary
J. A. Waggener, executive secretary

On motion of Drs. Taylor and McIntosh, minutes of the meeting held on January 14, 1968, were approved as printed.

Reports of Councilors

The councilors reported on the programs which had been arranged for their district meetings and invited the officers and members of the Council to attend the various meetings scheduled in April and May. (Dates listed on page 960, *Journal*).

Unfinished Business

Orientation Meeting. Dr. William R. Clark, chairman of the Council Committee for Orientation of New Members, reported that a meeting for new members had been scheduled during the annual convention for 9:30 a.m., Wednesday, October 16, 1968. Regarding an appropriation to cover the expense of this meeting, it was pointed out that unless some speakers are imported, the only expense involved would be the cost of promoting the meeting to new members. In order to assure a good attendance it was suggested that a letter be sent out over the president's signature to each new member, indicating the importance of the orientation meeting and then a list of the new members by districts be given each councilor in order that the councilors might personally contact each of these individuals by telephone or by letter, in an attempt to get as many individuals as possible present.

The secretary called attention to the Bylaws, Chapter I, Seetion 1, which states that "Every person becoming an active member after January 1, 1967, shall occupy a provisional status for two years immediately following his admission to membership in this society, during which period he must successfully complete an orientation course to be presented at stated intervals by the Council of the Indiana State Medical Association or one of its commissions. The form and content of this course shall be prescribed by the Council of Indiana State Medical Association."

In view of the discussion it was taken by consent that the Orientation Committee should meet again in an attempt to come up with the answers to the important questions which had been raised, and report to the Council at its next meeting.

Reports of Officers

DR. G. O. LARSON, President: Honorable Chairman, members of the Council, the Executive Committee, gentlemen:

Gentlemen—as we sit here this morning I am sure as we think back over our experiences of the past day and last night, we wonder how men who our patients have sent to Washington can come up with some of the laws under which we have to live. I believe that you would agree with me that most of these men as individuals leave us with the impression that their integrity is unquestionable and that they have a sincere desire to do the best they can, for the nation and for the people whom they represent.

We sit here this morning in this nation's capitol, the elected representatives of our members who have placed in us their trust that we would carry on in their behalf, be responsible for looking after their welfare and the welfare of organized medicine. I don't believe there is a one in this room whose integrity and desire to do a good job can possibly be questioned.

I further realize that too many of our members are willing to abstain from the affairs of organized medicine and too many are willing to assume that because they have elected us to this Council, it is up to us to make decisions in behalf of them, to protect their interests and to be responsible for setting the future course of the medical profession in our state. Yet on the other hand, each one of us has other primary responsibilities which preclude giving our full time and our full thought to what is good for our colleagues, what is good for our patients, and what is good for the medical association.

As for our congressmen, their duties are a full-time, paid responsibility. We represent a volunteer corps, attempting to give as much time as we possibly can in the interest of our profession. We will probably go unheralded and unsung; we will probably be open to criticism which we often are but that is our lot. Each of us, I am sure, has a deep desire and a sincere interest in where we are going. We are burdened with our first two responsibilities—that of taking care of our patients and rendering them the best medical care we know how. The second responsibility, of course, is to our families and to our own well being, such as some time for relaxation from the daily grind which we endure. Only third, I would say, comes our interest in the medical organization.

We today, who sit at this table, face many challenges, and I am sure that those who have preceded us, at the time they

sat in this same body, felt that the issues of their day presented great challenges to their organization and to their profession. However, I do not feel that many of those challenges, as serious as they were, are as far-reaching as those which are facing us now. I feel that we are upon the threshold of perhaps some of the most radical changes, made not only in medicine, but in the history of the nation. I think we must be aware of these prospective changes and how they will affect our practice, our organization, and the care of our patients.

In 1849 when this association came into being, there was a unified desire on the part of physicians to come together to discuss their problems, primarily, patient care problems, new techniques in caring for people and treating diseases. Another great motivating force in those days was the upgrading of medical education, to make sure that physicians in caring for the people were well trained and well qualified to give good medical care. Over the years this has continued to be the motivating force of the medical organization: we have fought quackery, we have encouraged new developments, new techniques and new ways in order to give the people of our state and nation the best quality medical care. Yet today, there are those who are beating the drums, stating that we are not fulfilling this purpose, that we have failed.

Since the start of the medical organization, up until the past few years, our opinions have hardly ever been questioned as to medical care, public health and all other facets of the well-being of our people. We were even looked upon as family advisors and our word became, more or less, law in the field of health and medical care. We came to believe ourselves the ultimate authority upon public health and this trust was placed in us by the people of this nation and our state. However, as time progressed and we look back, one sometimes wonders how we have strayed away from this image which made us such a powerful influence upon the people of this country.

As we have developed new techniques, become more affluent, we have tended to divide into specialization groups, and I might say that, in many respects, with the fast development of the science of medicine, this has been necessary. However, while these groups originally started as a basis for enhancing their own scientific abilities, I fear that they have tended to, in so doing, dilute the effectiveness of the medical profession as a whole. We now have in these groups, not only a desire to enhance their scientific ability and techniques and to develop a greater prestige for their type of practice but we have also seen developed special interest activities which have brought about a situation where they travel a narrow road and can no longer see the total public health picture as we once did. I feel it is time that we must revert to looking at the patient as a whole and I use the word "patient" in describing the public as a whole. No longer can we afford to determine that health, good health and good health care, relies solely within the realm of the surgeon or the internist, or the pediatrician, or the obstetrician. It is time that we again consider these groups not only from a scientific field, but also we must consider them together with the common thought of resolving the attacks upon the medical system which are apparent on every side today.

We came down here to visit with our Congressmen, to discuss issues as we saw them, to offer any assistance in answering any questions they might have on health legislation. We came down here to talk to federal officials about some of the laws which have been adopted and which have a far-reaching effect or which could have a far-reaching effect upon the future of the medical profession and our practice. Again as we sit here as their elected representatives, we are charged by our fellow practitioners with resolving their problems or at least offering solutions for their consideration. They have placed in us their trust that we will do the best for them and for their organization. Therefore, in spite of our other responsibilities, I would hope we could get ourselves in the position to more seriously consider, to discuss and to offer to our membership, the possible avenues for further progress in our profession.

If we would stop and think, we have seen in our lifetime many changes, not only changes in public attitude but in public habits, morals and every other facet of our life. Psychiatrists today state that the "hippie movement" is an indication of rebellion of youth to parental control. Some say that we have kept a child in the adolescent period longer than is necessary because we don't know what to do with them. Some even predict that within another decade or two we might even be back into practicing polygamy because we are going to see families reared earlier and parents will have completed the raising of their brood by the age of forty. The problems will then begin to rise in family living at that time. It is predicted that as the years come there will be more rebellion against our various establishments and the way of life as we have come to know it. This we must take into consideration, we must begin to give some thought, if these predictions are correct, and if so what is the ultimate result to be as far as our profession is concerned.

We are here today to discuss, in some detail, and give a lot of thought to the implications of public # 79-749 known as "Comprehensive Health Plan." If one reads the law and gives some thought to the content of this and to the writings of those who have spoken upon the subject, I think we can boil it down to one simple statement and that is. . . "How can we make first quality medical care readily available to everyone at a reasonable cost?" Taking this as a fact, I have come up with a few suggestions for your consideration, areas with which we might concern ourselves.

One. . .I believe that most of us believe there is a shortage of medical personnel in our state. If so, I believe then that it is up to us to take a strong position in favoring the establishment of a second medical school in our state and to define its location where we believe it will attract more students and afford good teaching material. If we feel this is the solution, then no longer do I believe we can afford to take a less than strong, positive position in this area.

Two. . .I think most of us down deep in our hearts realize emergency room care is far from perfect in our state. How can this problem be resolved? Either we must develop a profession that is going to handle emergency care in the home, or at the scene of the accident, or plan and develop and educate people on the proper use of emergency rooms strategically located throughout the state.

Three. . .We have been, over the years, and still are, conservative. We have taken the position we can do the job without federal interference or without outside influences. However, as the period of inflation strikes us, we find if we are going to tackle many of these responsibilities, it requires money. Therefore, I would suggest that we would consider the establishment of a non-taxable, charitable foundation for receiving and disseminating funds for use in health education and health care purposes. Think seriously about that.

Four . . . With the growing demand for medical care, should we study the use of medical assistance on the basis similar to the corpsmen set-up in the armed services?

Five. . .I believe that we must work more closely with voluntary health organizations and allied health groups in working out some of the problems that our public seems to think exist. If we are to do a good job in comprehensive health planning

then we must work closely with these people, as I see it.

Six. . .We should make an intensive study of the number of doctors needed for a certain number of individuals in a particular area, in order to make readily available first quality health care.

Seven. . .I know this is controversial but nevertheless I think we must study it and that is. . .are there benefits to be derived as far as public health care is concerned, through group or confederation type practice?

Eight. . .One of the provisions of the law deals with traffic safety. I think we must give serious thought to this area of health care as it relates to the physician.

Nine. . .We have been fortunate in not having many serious disasters but is the profession adequately prepared for a disaster which may arise at any given time?

Ten. . .Perhaps one of the areas to which we should give very serious thought and searching study, is the area of medical education. Does a physician need further training before entering private practice or should we determine if we can lower the standards of qualifications for entering the schools of medicine and thereby bring more men into the field rather than utilizing foreign trained physicians?

Eleven. . .Another very important factor which I believe is essential, is the relationship of physicians to hospitals. I am sure that each of us sitting here today realizes that within the past 25 years hospitals have entered more and more into many of the areas which were formerly considered the practice of medicine. As we read and hear those who are making pronouncements in this area today, we can see the intent and the trend is to make the hospital the health center, the authority in health, with full-time salaried physicians.

Twelve. . .Another area in comprehensive health planning is air pollution, water pollution and these are areas in which we have a very definitive responsibility to lend our assistance in making the air we breathe clean and the water we drink pure.

Thirteen. . Knowledgeable as we are and with the lack of manpower, if we agree that there is a lack of manpower, then should we further sublet the practice of medicine to others? I mean by this, should we develop in nursing and in other groups the training and the authority to do many things that a physician now considers his sole right? As you may well remember the White House Conference of a few years ago, in which it was pointed out we were misusing manpower, that we can train other people to do many of the things a physician now does, in order to free the physician for those services which only he can give.

There are a few other recommendations I want to make at this time. The first one is, at the next Council meeting, comprehensive, up-to-date reports on the activities of all committees and commissions should be given. For example, plans of the Commission on Legislation, for a bill to implement Medicaid in Indiana. I would recommend that these Council reports, except in a few specific instances, be given to the Council every other Council meeting. Commission and committee chairmen should have adequate notice and opportunity to prepare these reports.

Two: We must soon have a financial committment from the State Board of Health if we are to proceed with the areawide planning program, as we have reached the point where further efforts will cost money and the ISMA cannot carry much, and probably should not carry any of this burden.

Three: If you have not already done so, I would urge each of you to read the article entitled, "Crisis Ahead in Medical Care", published in the February 26 issue of *U.S. News and World Report*. Please pay particular attention to the reported remarks of Dr. James Z. Appel, recently given to the Philadelphia County Medical Society.

Four: I read this to the Executive Committee the other day but I shall repeat it now. As I have indicated to you previously, it is my desire to reactivate a program which was for some time an annual custom but which has, in recent years, been abandoned. I refer to the annual Conference of County Medical Society Officers. It is my considered opinion that this offers to us our best means of communication at the present time. At the conclusion of my remarks I shall call on our executive secretary to outline proposals, including dates, program, etc., which we have discussed. I shall then request of the Council authority to proceed to implement this plan.

These are some of the things I think we should think about and there are many others which I could enumerate but I am hoping that as a result of this meeting today we can come to some definite conclusions of areas of study and investigation and a positive approach to some of these problems. I think we have a responsibility for facing these squarely, for contemplating them, and giving thought as to how they can be resolved. I do not think we can afford any longer to think that this is a bad dream that will go away somehow. . . .I don't think that it is going away. . .I think there are those forces at work. . . I think they have the public mind in the proper mood to continue to question our leadership and our ability in rendering first quality health care to the people of our state and our nation.

I notice the Indiana Hospital Association is requesting an annual grant of $50,000.00 a year from Blue Cross in order to "beef-up" their staff to do their share of planning. I think we must agree that the hospital group is far ahead of us in areawide planning as it relates to hospital facilities. I am sure if the medical profession is to carry out its responsibility and not default in the areas in which we should be the leader, then we too must give some serious thought to "beefing-up" our operation in order to accomplish this work.

There are those who feel that the Congress will never fund this particular program but even so these things normally don't have a way of going away too quickly. There are those we know in the government who are dedicated to bringing some of these ideas into fruition. I don't think that we can afford to wait until they are thrust upon us before we start to think and to plan. I think, gentlemen, the time is now, and, perhaps most important, we must find a way to communicate with our membership—to fully acquaint them with the facts as we see and know them. We must convince them this is serious business.

I appreciate your attention, I am sorry that I have to appear in such a serious vein this morning but I hope that I have given you some matters for you to think upon and I hope we shall all find the time to give serious thought to these challenges and to these problems which face us today.

Thank you.

It was taken by consent that the item relating to the County Society Officers Conference would be taken up as an order of new business later in the meeting, and that the entire address of the president shall be sent to each councilor for his perusal and that the suggestions contained therein will be taken up as an order of new business at the next meeting of the Council.

DR. PATRICK J. V. CORCORAN, President-elect: Mr. Chairman, Mr. President, members of the Council, Executive Committee, and staff: These meetings are good because we do have time to philosophize and to grapple with concepts and take a long overdue view of situations to which we often cannot otherwise devote the proper attention. In considering them, some attention ought to be given to semantics because they have labels that are

emotionally charged; for example, "liberal", "conservative", "progressive", whatever you will. Using these terms in dealing with problems is sometimes slightly defeating and I eschew them to the degree that I am able. We are in the last third of the twentieth century: we must orient ourselves accordingly and, insofar as we can, be *realists* with *contemporary* attitudes. It has been a real exercise in self-development for me to sit at this table and hammer out programs after a discussion with men of differing professional and environmental experience, who come from areas with problems that are not always quite the same as I face in my own community. And we generally forge a pretty workable solution to these. I have now arrived at a point where I accept the fact that we are all men of good will who are honestly dedicated to doing the best job we can for organized medicine. I don't impugn the good will or the motives of anyone involved.

Our professional lives are changing. I am told the half-life of medical knowledge is about five years. Our personal lives are subjected to the same bewildering pace. I can't get over how every doctor of almost any age can and does avidly accept the latest techniques or methods or treatments in his practice of medicine. We should adopt this attitude in our social and economic lives and be truly objective. In medical practice, the clinical course of the patient, or the opinions and advice of consultants can be ignored only at our peril because sooner or later the inexorable passage of time reveals what is true. Occasionally it's the autopsy. This carries over into other phases of our lives.

Now, I was impressed up on the Hill yesterday with the tone of youth which is beginning to permeate our government. I am beginning to be concerned with the attitudes of our members who are in practice ten years or less and with the medical students, who are our professional heirs. As your president, when it comes my turn, I feel it will be my obligation to be responsive to their opinions and their objectives.

The delivery of health care is our primary problem: particularly the *effective* delivery rather than the mere availability of health care. Our president has just referred to the quality of it. Some appraisal of what is the standard of quality is pertinent. Take housing as an example; I doubt that anybody advocates the practicability of top quality housing for everyone. There will be a standard, and this carries over into the delivery of health care. There must be a standard. Not everyone, obviously, can have the highest and top quality care. A multitude of problems are coming to us. I do solicit your suggestions so that we can program the coming year as effectively and as productively as possible. Time is accelerating and my own deadlines will be upon me very soon. Thank you.

DR. LESTER H. HOYT, treasurer, reported that the association had sufficient cash in the bank to cover current operations and that a cash surplus of $150,000.00 had been invested at 5 1/4% interest in a Certificate of Deposit which will mature in May, 1968. He also reported that as instructed by the Executive Committee and on advice of the Council, he had contacted an investment counselor who estimated that his fee for reviewing the association's investment program would be $50.00, and that the Executive Committee, at its meeting on March 6, had authorized an expenditure of up to $50.00 for this study.

Matters Referred to Council by Executive Committee

DR. RALPH V. EVERLY, chairman of the Executive Committee, presented the following matters:

1. *County Medical Society Officers Conference.* The proposal of the Executive Committee to hold a conference of county medical society officers on Saturday, March 30, and on Sunday, March 31, at an anticipated cost of $4,250.00, was discussed by many.

On motion of Drs. Taylor and McIntosh, the Council approved the proposal, to be financed out of the operational funds of the Indiana State Medical Association if other subsidy cannot be obtained.

2. *Junior-Senior Day program.* The format for the Junior-Senior Day program, prepared by the Commission on Public Information, was reviewed by the Council, as was a letter from Dr. Steen concerning this subject. **On motion of Drs. Dukes and Wilhelmus, Dr. Steen's comments were received as information only.**

3. *Selection of a "Miss Indiana Good Health."* Dr. Everly reported that the Commission on Public Information had explored the idea of selecting a "Miss Indiana Good Health," the nominations to come from the county medical societies, and announcement of the selection to be made at the annual convention of the association, with an appropriate award to be made. Following discussion by several, **on motion of Dr. Donato, seconded by many, the Council voted disapproval of the project.**

4. *Receipt of commission reports.* Drs. Taylor, Steen, Corcoran and Hoyt discussed the failure of the councilors and officers to receive all of the minutes of the commission meetings. The chair announced that this would be taken as a matter of information, to be acted upon accordingly by staff.

The chair also suggested that commission reports, unless they are in final form and can be mailed to the councilors in advance, not be made an item for Council discussion until such time as the councilors have had an opportunity to read and study them even though it may delay action on some items. If emergency items arise, the commission chairman concerned is to be asked to appear before the Council and present the matters for discussion. **These suggestions were accepted by consent.**

5. *Better professional cooperation with allied groups.* Dr. Everly read from the report of the Commission on Public Information:

> "In the interest of improving professional relations with allied groups, the commission recommends to the Council that the Indiana State Medical Association invite to the annual convention each year the membership of the following organizations: Indiana State Dental Association, Indiana Veterinarian Association, Indiana State Nurses Association, Indiana Hospital Association, and the Indiana State Association of Physical Therapists and Laboratory Technicians."

The chair referred this matter to the Council at its next meeting, to be taken up as an item of unfinished business.

6. *Budget for health educational material.* Dr. Everly read from the report of the Commission on Public Information as follows: "The commission expressed the opinion that since requests for literature on health matters continue to come to the ISMA, a budget of $300.00 be requested of the Council to meet the cost of these materials which in practically all cases must be purchased from the American Medical Association."

The chair ruled that this matter be deferred until the next meeting of the Council, to be taken up as unfinished business.

7. *Placards listing voluntary health agencies.* Dr. Everly again referred to the Council the matter of distribution by the Commission on Voluntary Health Agencies of placards listing the various voluntary health agencies. **On motion of Drs. Taylor and Kerr, the chairman of the Commission on Voluntary Health Agencies is to be invited to attend the next meeting of the Council to discuss this matter, and decision of the Council is to be deferred until that meeting.**

8. *Meeting with other medical groups.* Dr. Everly read the following letter, proposed by the president-elect, Dr. Corcoran:

Dear Doctor_____:

The Indiana State Medical Association is proposing that its annual meeting, usually held in October, be arranged in conjunction with the meetings of other Indiana physicians' organizations, as is done in some other states.

Many advantages could redound to those involved, such as strengthening the scientific programs, expanding the (scientific and commercial) exhibits and, possibly, increasing interest in the social and entertainment features, through widened participation.

We envision that the section meetings of ISMA would be, in effect, supplanted by the appropriate groups; for example, the Section on Internal Medicine would function through the meetings of the College of Physicians and the Society of Internal Medicine.

Such sessions could be concurrent or immediately precede or follow the ISMA meeting. This would relieve members of the need to choose between attending the annual meeting of the ISMA and any of the other state groups, with resultant economies of time and money.

Would you please consider this proposal and let us know whether your_____ (association, society, or other appropriate term) might be receptive to this project and, if so, under what circumstances or conditions, as well as the earliest annual date which would be feasible.

You may contact Mr. Waggener, Dr. Larson, or Dr. Corcoran for further information or details.

Dr. Reid moved that the Council approve the project in principle and that the chairman of the Council appoint a special committee to work with the appropriate commission to pursue the idea. Motion seconded by Dr. Dukes, put to vote, and carried. (Assigned to Council Committee on Membership Matters).

9. *119th annual convention, Fort Wayne, October 15-18, 1968.* The Council reviewed the tentative outline of the program.

a. *Socio-Economic meeting.*

The chairman read the following letter from Dr. John L. Ferry, a member of the Commission on Convention Arrangements:

"This letter is written in support of the viewpoint that the Socio-Economic session of the state meeting be open to the public.

"The Commission on Convention Arrangements has expended much effort in planning the association's annual meeting in an effort to accomplish two particular goals:

1. An excellent program in order to increase attendance and participation of members.
2. Improvement of the association's public image.

"The program in question, 'Medicine in the 70's and 80's' is essentially noncontroversial. The inclusion of this subject on the program should indicate the association's concern in meeting future needs and dispel the notion that we are only interested in preserving the status quo.

"Extending an invitation to groups who are not necessarily friendly to organized medicine, i.e., the Legal Association, nurses, etc., hopefully may improve their opinion of us.

"Finally, the auditorium at Fort Wayne is enormous, and a small attendance will appear to be tiny in that setting.

"I respectfully request, as an individual commission member, the Council's consideration of this matter."

The chairman amplified the thoughts contained in the above letter, saying it was not the idea of the Commission on Convention Arrangements to throw the doors wide open to the citizenry of Fort Wayne but rather to invite the nurses from the Fort Wayne hospitals and physicians' offices, also the local dentists, and perhaps representatives of the bar association, to attend the socio-economic portion of the program. Dr. Larson added that the members of the woman's auxiliary should be invited and encouraged to attend this meeting so that they may have a better understanding of the problems which face organized medicine.

On motion of Drs. Kerr and Wilhelmus, the Council voted approval in principle of inviting the groups so mentioned to the socio-economic program.

b. *Council dinner.* Dr. Clark announced that the Twelfth District Medical Society may decide at its district meeting in May to host an evening's entertainment for all those in attendance at the convention and this would be scheduled for Thursday evening, October 17. In view of this, **it was taken by consent that the annual Council dinner, previously scheduled for Thursday, October 17, would be re-scheduled for Monday evening, October 14, and it will be formal.**

c. *Televised reporting.* Dr. Everly read a letter from Televised Medicine, Inc., New York, offering to conduct without cost to the association closed circuit television reporting of the convention to the various hotels in Fort Wayne. It was the consensus of the Executive Committee that this might be acceptable providing TVMI bought an exhibit booth.

Dr. Taylor, in discussing this offer, called attention to two points:

(1) This is obviously a commercial enterprise; the people putting it on are going to make money on it or they wouldn't be interested. Why shouldn't the association also derive some benefit from this in a monetary sense, perhaps on a percentage basis?

(2) Since advertising is going to be involved we should know who is going to advertise. Since we have banned tobacco companies, we should be sure that these are not being televised into the rooms. Also, if some drug company or other sponsor advertises on this, at no expense to them, so far as we are concerned then our advertisers who are buying booth space would have a legitimate complaint. I don't believe that any company should get free advertising insofar as we are concerned.

Dr. Everly stated that the advertising would be subject to the association's approval.

On motion of Drs. Reid and Dukes the Council voted to refer this matter to the Commission on Convention Arrangements with instructions that the commission consult with TVMI and work out the details, taking into consideration the commentary of Dr. Taylor, specifically the choice of advertisers and the financial arrangements that may be made, and submit its findings to the Council for a policy decision.

Economic and Organization Matters

1. *Washington dinner.* **By consent, Dr. Joe Black was given the privilege of the floor.** Dr. Black discussed the location of the dinner meeting which is held in Washington each year and asked if the officers and the Council would like to have him pursue the idea of having this dinner in the future on the Hill, as a courtesy to the staffs of the congressional people and the Senate. "We have had a proposition, for example, that we might have this in the Senate Office Building or in the Rayburn Building."

On motion of Dr. Dukes, it was taken by consent that Dr. Black should look into the matter of location for the dinner, and that the make-up of the invitation list should be left to the discretion of Dr. Black and Mr. Waggener.

In response to Dr. Steen's inquiry, all

councilors expressed the feeling that the meeting in Washington had been illuminating and very much worthwhile.

2. *Membership report.* The secretary presented the following report:

ISMA members as of 2/29/68	3,574
ISMA members as of 2/28/67	2,986
Increase	588
Number paying IMPAC as of 2/29/68	1,520
Number paying AMPAC as of 2/29/68	1,501
AMA members as of 2/29/68	3,445
AMA members as of 2/28/67	2,883
Increase	562

3. *Remission of state dues.*

a. **On motion of Drs. Kerr and Wilhelmus, remission of the state dues of a member of the Third District because of illness and retirement from practice, was approved.**

b. **On motion of Dr. Steen, seconded by many, remission of the state dues of a member of the Tenth District because of retirement from practice, was approved.**

c. **On motion of Drs. Clark, Scamahorn and Wilhelmus, remission of the state dues of a member of the Twelfth District because of retirement, was approved.**

d. **Action on requests for remission of dues of some members in the Thirteenth District was deferred until the next Council meeting due to the absence of Dr. Bowen, councilor.**

4. *Nominations for Editorial Board.* **It was taken by consent that the Council Committee of Business Consultants for The Journal shall discuss with the editor of The Journal the nominations of two members to fill the terms of Drs. Alvin J. Haley, Fort Wayne, and Wei-Ping Loh, Gary, which expire December 31, 1968, and report to the Council at its next meeting.**

Dr. Clark recommended Dr. Haley to succeed himself for the three-year term ending December 31, 1971.

Matters from Council Committees

1. *Council Liaison Committee with Blue Shield.* a.) Dr. Donald M. Kerr, chairman, reviewed correspondence with a physician concerning his coverage under the Blue Cross-Blue Shield Physicians' Program, and his objection to the refusal of a Blue Shield representative to give him figures on the number of physicians involved in the Medicare program. Dr. Kerr recalled that about a year ago the Council concluded that Blue Shield should not release these figures and said that his contingent recommendation would be "that we should continue to advise Blue Shield not to use these figures as we decided they could be very misleading, and I think we owe them that much defense."

Dr. Kerr moved that the following letter be submitted to the presidents of the county medical societies and to Blue Shield, and his motion was seconded by Dr. Clark:

"Re: *Mr. Dixon and Statistics*

"In the early reports to the Council by Blue Shield after the beginnings of Medicare, there were references made to the number of doctors in Indiana who were taking assignments. It was immediately apparent that the figures could be interpreted in many different ways and be used to 'prove' almost any point the user chose to make. They could not be current, they were a compilation of figures from multiple sources, and it was impossible to verify their accuracy.

"These figures had been used by Mr. Dixon in discussions with various county societies and for the reasons above stated were found to be objectionable by the county society members.

"The Council of the Indiana State Medical Association, *without specific formal action,* suggested that Mr. Dixon not use the figures in future discussions. He agreed to follow the recommendation and has declined to release the figures in discussion since that time.

"It is now apparent that these moves of the Council and Blue Shield, made in good faith by both parties, have been misinterpreted as an effort by the Council to suppress information. This was not and is not the fact and should the counties so desire, the Council will urge the Blue Shield representatives to give all the numbers, meaningless and misleading as they may be. It should be recalled that the figures were used by some press representatives and government agencies in such a fashion as to give a false impression that the medical profession had jumped vigorously onto the Medicare bandwagon, and will no doubt be so used again if the raw figures are disseminated.

"Please notify the executive secretary of the desires of your county.

"Donald M. Kerr, M.D., Chairman,
Council Liaison Committee with
Blue Shield."

On motion of Drs. Dukes and Donato, the Council voted to amend Dr. Kerr's motion to specify that this memorandum be sent only where controversy arises. Motion, as amended, put to vote, and carried.

b.) Letter was read from a Lafayette radiologist concerning billing separately for his services. Dr. Kerr reported that he had talked with Mr. Kilborn regarding this matter and Mr. Kilborn had stated that it was agreeable with him for a physician to bill separately, but to properly dispose of an entire item of a patient, Blue Shield, because of the breakdown of the hospital's charge and the doctor's charge that must be made technically, should receive all bills simultaneously. Mr. Kilborn therefore asks that these two bills be sent in together in order that Blue Shield may handle each patient total x-ray problem at one time rather than having to coordinate a bill which may come two months later for the radiologist's service with a bill received two months earlier from the hospital for the hospital's part of this charge.

Dr. Kerr: It would be my recommendation, from the information available to me, that the Council suggest that this is not unreasonable behavior from the Blue Shield to ask that there be coordination of these bills, so that the payment for services rendered to a patient on the part of the hospital and the radiologist can be done at one time.

Discussed by Drs. Taylor, Dukes, Reid and Neumann. Dr. Neumann suggested that this matter might be worked out successfully if the charges from the radiologist and the hospital were put in a "hold file" until treatment is completed. Dr. Neumann was instructed to talk with Mr. Jones of Blue Cross in an attempt to work in this direction. The chairman of the Council suggested that Dr. Petrich, as a resident of the Lafayette community, "be empowered to attempt to effect some negotiation in this regard as a member of the Indiana State Medical Association Council Liaison Committee with Blue Shield."

It was taken by consent that a copy of the letter from Dr. Lowell Thomas and also a copy of the letter from Mrs. Lowell Thomas should be given to Dr. Kerr for any use that the Blue Shield Board might wish to make of this correspondence at its Board meeting.

2. *Council Liaison Committee with Blue Cross.* Dr. Donald R. Taylor, chairman, presented the following report: I have a lengthy and detailed report here; I hope you will bear with me.

Basically, my activities with the Blue Cross Board during the last two months has been one of attempting to understand and perhaps influence in some way or other the relationship between Blue Cross and the Indiana Hospital Association in terms of their planning activities. I think, in order to understand this, you need a lot

of background information as to how this functions, and as briefly as I can, I will outline that for you. At the present time this functions basically as an evaluation of requests for rate increases to Blue Cross as such increases relate to proposed capital expenditures. It is basically the capital outlay expenses that have become involved in this matter.

If a hospital submits a request for rate increases to Blue Cross that entails an accumulation of capital moneys for expansion of the hospital, new building program, or this sort of thing, Blue Cross evaluates this request for an increase through their rate review committee, on which we have medical representation. There is one doctor who does sit on this particular committee. One of the tests that this rate committee applies to a request is to see if the capital improvement that is being contemplated has been cleared through an areawide health facilities council of one type or another that operates in the local community involved, and unless this has been done Blue Cross per se refuses the rate increase. The present regulations require that this be looked into locally by an areawide planning program consisting of community representation and others.

Of course, this brought up a rather deep discussion as to how these local planning councils are constituted, who serves on them, and all this sort of thing. Now, this, I think, is of interest to us because it is our feeling that these councils are only one step removed at the moment from areawide planning councils in comprehensive health. At the moment they are termed health facilities planning councils which would imply only hospital and perhaps nursing home activity, but from other actions of the Indiana Hospital Association we feel that they are simply one step removed from comprehensive health councils. So, at our meeting on January 25, and again at the meeting in February this was our main item of discussion. Incidentally, this whole thing, I think, was brought about by the efforts of Dr. Neumann, and Dr. Rifner probably to a lesser extent, wanting to get the medical profession informed as to how the Indiana Hospital Association and Blue Cross were functioning. This was a very illuminating meeting to me, the one on January 25. Out of this we requested that Mr. Jones, who is the professional representative of Blue Cross, secure certain information for us and which he tried to procure in a letter to Mr. Graham of the Indiana Hospital Association. He summarized this in a letter to Graham:

"Subject: SUMMARY OF ISSUES, MEDICAL ADVISORY COMMITTEE OF BLUE CROSS

"The following items represent the concerns of the physicians at our meeting on January 25:

"1. Physician representation for any planning council should be drawn from either the hospital medical staff or the county medical society, preferably the latter;

"2. He should not be hand picked by the hospital administrator but he should, instead, be selected by physicians."

We objected to certain terms utilized in their policy statement and requested definition of them. And we requested that certain wording changes be made in the hospital association's manual on health services, and then indicated that there is a definite need for increased coordination between the Indiana Hospital Association and the Indiana State Medical Association on any major activity involving planning. In addition, the Medical Advisory Committee made the following requests:

(1) Of the planning councils now endorsed by IHA, they would like to know the manner in which the physician representatives have been selected.

(2) We requested that they send us a list of endorsed planning councils to date. At this time these planning councils are endorsed by the Indiana Hospital Association well in advance of else.

(3) The Medical Advisory Committee requested that the board and the Executive Committee of Blue Cross Board be supplied copies of the revised planning statement from the Indiana Hospital association well in advance of any date on which they had to vote on the subject.

And then we requested that Mr. Jones reduce certain information that he had furnished to us into a chart which we would have available for our reference. This has been done, and we can supply this to the state association.

Then Mr. Graham, representing the Indiana Health Facilities Planning Program, replied by letter to some of these questions. In reply to item "1" which was desiring information on how physicians were appointed, he stated that "The Indiana Hospital Association and the Health Facilities Planning Program urges hospital administrators to include at least two or three physicians on each planning council. We suggest the president of the hospital medical staff, a representative from the county medical society, and the county public health officer, might be suitable representation."

Then he makes a statement which I think we should clarify for him: "As you know, in most counties the county society and the medical staff are synonymous." They may include the same individuals but I don't think the two are synonymous. This is a matter of philosophy perhaps but a hospital staff is subject of course to veto action of the board of trustees at any level of its activities, whereas as a member of a county medical society one is an independent individual, and this is the only organization in my opinion that has only the interest of the physician at heart and if a physician were appointed from the county medical society to one of these planning councils, I think that his position would be much stronger than if he were appointed as a member of the hospital medical staff.

Then he furnished us with a breakdown of counties insofar as their hospital status is concerned. This might be of interest to you. There are 53 counties in the state that have a single hospital. There are nine that have two and four with three and two with four hospitals, and 17 counties have no hospitals at all. He agrees that certain terminology used in their planning policy statement should be clarified so that both parties understand the definitions.

Then, so far as cooperation between the two organizations is concerned, he indicated that they have also been concerned about this and desire closer coordination, not only in planning but in all areas of medical interest, which you can't argue with. As you know, Mr. Robinson has attended at least two planning council meetings in Hendricks county, in central Indiana, and we have begun to have staff meetings involving our staff and theirs, and he says they "would appreciate the opportunity to have physicians advise and make recommendations in this area." I understand there is an invitation that we participate with them to a greater extent.

Now, the second series of questions. He replied to item "1" which requested a list of the planning councils now endorsed by the Indiana Hospital Association. He supplied this and further stated, "Attached to this memo is a list of the councils with the physicians presently serving as board members." Looking over this, it so happened in my own county, Delaware County Planning, Inc., that they list a Dr. Robert Bell who is not a physician but is a Ph.D at Ball State University. He is listed as a physician member. This was brought to their attention and Mr. Graham is supposed to strike his name from the list of physicians.

As far as I recognize the names from the

other counties these are all practicing physicians, and if anyone wants to see this list I certainly will be glad to let you see it.

Then he goes into a short discussion on how these councils were initiated in the various counties and what their present status is.

Then he presented a list of the endorsed planning councils to date. These include councils in Delaware County, Tippecanoe, Marion, St. Joe, Greene, Gibson, Hancock, Henry, Elkhart, Kosciusko, Marshall, Rush, Vanderburgh, Vigo, Tipton and Wayne and then the single regional council which is made up of several counties formed into a central Indiana council made up of Marion county and the contiguous surrounding counties.

We further requested that their revised planning statement be supplied to the Medical Advisory Council and this has been done, and I think Mr. Waggener has a copy.

This did afford your liaison member and certainly the medical members of the Board of Trustees of Blue Cross a working knowledge of how the Indiana Hospital Association planning council is presently functioning.

The next step in this activity occurred when Dr. Neumann attended the Executive Committee meeting of Blue Cross, of which he is a member, on February 22, at which time he was confronted with consideration of a request that was made to the Executive Committee by Mr. Spring in which Mr. Spring distributed copies of a proposed expansion of the health facilities planning program by the Indiana Hospital Association, in which they indicated a need for additional staff personnel and office expenses in order to carry out their functions. Prior to this statement, they requested a donation of $50,000.00 per year by Indiana Blue Cross to the Indiana Hospital Association in order to finance this increased activity of their health facilities planning program.

After considerable discussion, action on this request was deferred until the next meeting of the Blue Cross Executive Committee. In order to put this in proper perspective I would like to read a letter that Dr. Neumann sent out to the members of the Medical Advisory Committee;

February 23, 1968

"To: Medical Advisory Committee
Blue Cross Board

"At the meeting of the Blue Cross Executive Committee on 22 February 1968, the attached "Proposed Expansion of the Planning Program" was presented along with a request for Mutual Hospital Insurance Inc. to provide "up to $50,000/year" for the addition of "staff members" or "field planners" for the Indiana Hospital Association, perhaps on a yearly basis. This seemed to be a very extensive and expansive program, and to me indicated considerable IHA supervision (direct and indirect) on "local" planning.

"I objected vigorously to such an immediate expenditure and finally arranged to defer such action until the Medical Committee has had an opportunity to discuss and evaluate this request. For this reason I requested that a special meeting of the Medical Advisory Committee be called for Thursday, February 29th.

"My objections were based on:

"1. I did not feel this type of planning was contemplated when we discussed this matter at our last meeting.

"2. Although there is a vast difference between Comprehensive Planning and local or hospital planning, I think there is a definite inter-relationship and they must be considered jointly in many respects.

"3. In view of the preliminary discussions that have taken place between the ISMA staff and the IHA staff—and the fact that these have been merely exploratory in nature; I felt that any sudden overt surge in a unilateral planning effort could only lead to further distrust, both on a state and local level and could create serious problems.

"4. I felt the Medical Advisory Committee should carefully review the implications of the proposal and the ISMA representative should have an opportunity to acquaint the ISMA Council with this proposal. I did not feel that a delay of one month until the Blue Cross Board meeting would cause any irreparable harm:

"I am well aware that the entire Board will probably approve this appropriation; but I feel prior knowledge by the medical group will perhaps minimize the repercussions I am sure will be forthcoming.

"At this time I do not know if this has been a subject of staff discussions between IHA and ISMA or not, but from all the information I have had, discussion has not occurred on this basis. I am sure we are all in agreement with the philosophy of "local planning", but the means and methods to be used need much study and a great deal of broadly based local participation, medical representation that reflects the medical community, as well as outside "expertise." How this can be assured without disruptive disputes is a pressing problem.

Sincerely yours,
Kenneth O. Neumann, M.D."

cc: Mr. Guy Spring
ISMA Headquarters

The next meeting of the Medical Advisory Committee was on February 29 and this was discussed in some depth. I think you should also be made aware of the proposed expansion of the hospital planning program. They state their reasons for needing two new staff members include such things as:

1. Support each hospital administrator as a planning staff specialist, providing data and background information for each planning council meeting,
2. Serve as hospital planning staff to the planning council upon request,
3. Assist in the formation of sub-regional councils,
4. Interpret state and regional statistical data,
5. Initiate new and/or special statistical studies,
6. Coordinate the use of other IHA services by local planning councils,
7. Assist and encourage the development of regional planning councils,
8. Act as a liaison between the voluntary planning councils and government agencies, and,
9. Serve as a communication mechanism between local planning councils and the IHA Council on Health Facilities Planning.

One thing that came up for considerable discussion at our February 29 meeting was this matter of how physician representation was to be secured. We attempted to get Mr. Spring to commit himself to the stand that Blue Cross would insist that this physician representation come from organized medicine and not from hospital staffs for the very reason that I explained to you before, and he assured us verbally that he would work toward these ends. We pushed him even farther and asked him to supply us with a written statement to this end. He sent a letter to me which is not quite as strong as he verbally stated, but probably does represent some minor concession at least. His letter states:

"I am enclosing a letter received from Mr. TeKolste relative to physician representation on planning councils which we discussed during our last Medical Advisory Committee meeting. Let me assure you that it is also my feeling that planning councils should include representations of the independent physicians. It is my intent to give my full support to the inclusion of such a requirement in the new planning guidelines now being developed by IHA." And the letter from TeKolste he refers to is as follows:

"In its past efforts to organize planning councils the IHA has insisted on medical representation. As you know, we are currently revising the planning principles. In this revision we will recommend to the Board and work toward the adoption of the phrase indicating that at least one independent physician not chosen as a representative of a hospital medical staff shall be included in the council membership. Specifically, I will recommend that in a certain paragraph the following phrase be added in the place indicated, "including at least one independent physician."

I think this is an expression of what I consider to be the stand of most hospital administrators, that is, they attempt to bypass the county medical society—refuse to recognize that this is a group with which they must deal. At least in my experience I feel that most hospital administrators feel that they have to deal only with the medical staff and not with the county medical society.

Discussion ensued and in answer to a question Dr. Taylor stated: It is my belief that we as members of organized medicine have to insist that representation on any of these councils that we recognize, be appointed by the medical society involved either on a local, district, or state level.

The reason I thought this should be presented prior to Dr. Donato's presentation was that we have to realize that they are just one step from areawide planning under the comprehensive health thing—the way they have this health facilities planning council presently set up—and certainly they are putting themselves in a position where they could move quickly from only hospital facility planning to comprehensive health planning.

The chairman thanked Dr. Taylor for his very complete report.

3. *Council Committee on Emergency Medical Services.* Dr. Lowell J. Hillis, chairman, reported on the following matters:

(1) *Communications.* Dr. Hillis said his committee had discussed this subject. The Bell Telephone has assigned the number 911 as the universal telephone number for emergency situations. "This has already been started by General Telephone in Huntington County, Indiana, which, I am told, is one of the very few places in the country where it will be operational, although there are some places on the east coast where they are attempting it.

"General Telephone is now spending a lot of money in Fort Wayne, Lafayette, Logansport, Elkhart and all over the northern part of the state to upgrade their service. I have been told by Mr. Platte, that eventually they intend to carry this thing through the whole General system, and of course Bell will go along with it, which leaves them with the independent companies in the state which will probably not go along with them at this time."

(2) *Traffic Safety.* "This morning I had an appointment with Robert Oswald, Director of Safety, American Red Cross, and we discussed the National Highway Traffic Safety Law of 1966. He showed me a paper which says that the State of Indiana has available $106,000.00 for the study and implementation of any of these sections of the Highway Safety Act. . . .Mr. Waggener gave me a paper today, dated March 1, which is a note from Mr. Bush to Mr. Waggener in which he says that on February 29 he had attended a meeting of the Governor's Advisory Committee on Emergency Medical Services. . . . All of these discussions that I have listened to on the national program have been divided into four topics: (1) First aid and rescue, (2) communications, (3) ambulance and transportation, and (4) emergency departments. The Indiana group has elected to add two more—education, and liaison on standards committees. . . .There is a notation on this paper that Indiana has received $32,000.00 for a twelve months' period for materials, conduct of surveys and staff assistants. Now, the total this morning, as shown in the paper, was $104,000.00.

"Mr. Bush lists in his memorandum the people who attended the February 29 meeting: Dr. Carl Martz, Dr. John G. Suelzer, Dr. Harry Becker, Dr. Joe Davis, Marion, Robert Yoho, Dale Harmon, Robert Rogers, Elton TeKolste, Bill Brennan, etc. . . . This is an intricate part of comprehensive health planning and so far as I can see, except that these men that I mention are doing it, then organized medicine has been eliminated." This was discussed by several, and **it was taken by consent that the president and the executive secretary "should make certain that Dr. Hillis, and perhaps another member of his committee, is represented on the Governor's Advisory Committee on Emergency Medical Services."**

The chairman thanked Dr. Hillis for the excellence of his report.

4. *Council Committee for the Study and Implementation of Governmental Medical Programs.* Dr. Albert M. Donato, chairman, proposed that he and a committee of three, consisting of Dr. Taylor, Mr. Robinson, attorney, and the executive secretary meet with the Indiana Hospital Association and that the physician representation on the planning committees be at least 25%. **By consent, the Council adopted the recommendations of Dr. Donato.**

5. *Council Committee of Business Consultants for The Journal.* Dr. Joe Dukes, chairman, announced that this committee would meet before the next Council meeting and would have a report at that time.

6. *Council Committee on Economics and Fiscal Matters.* Dr. Robert M. Reid, chairman, informed the Council that this committee will meet before the next meeting of the Council.

7. *Council Committee for Orientation of New Members.* Dr. William R. Clark, chairman, will have a report at the next Council meeting.

8. *Council Committee to Study Membership Matters.* In the absence of Dr. Otis R. Bowen, chairman of this committee, the chairman of the Council read the following report from Dr. Bowen, dated February 24, 1968, which was taken as a matter of information:

> "The membership of our committee felt that the survey questions would best be prepared by the field secretaries and the executive secretary. Would it be possible for a questionnaire to be prepared in rough form for our committee's perusal at the April meeting? Also, would it be possible to have a copy of Resolution No. 24 for each member of our committee for the April meeting so we may study it previous to the Council meeting? We will have no report for this meeting."

New Business

"Free circulation medical magazines." This subject was discussed by Drs. Wilhelmus, Taylor, Hoyt and the chairman, and Dr. Wilhelmus was asked to prepare a resolution regarding this matter for perusal of the Council at its next meeting.

Date for Next Meeting

By consent, 9:00 a.m., May 19, 1968, was selected as the date for the next meeting of the Council.

Space contributed as a public service by this magazin

Pick one to die.
Pick one for jail.
Pick one to waste away.
Pick three for happiness.

Some children find happiness easily. Others need the help and guidance only a trained person can provide, medical attention they cannot afford, love they have been denied. When you decide to give to your United Fund or Community Chest, you may change a life.

Your fair share gift works many wonders/THE UNITED WAY

UNITED

ADVERTISING COUNCIL

27 million families benefit by child care, family service, youth guidance, health programs, disaster relief and services for the Armed Forces from 31,000 United Way agenc

COMMERCIAL ANNOUNCEMENTS

BUY AND TRY: Wye Plantation Aberdeen-Angus frozen semen from Advanced Register P.R.I. sires officially gaining over four pounds per day or whose 365-day weights are above 1,200 pounds. (Performance tested sires always for sale.) WYE PLANTATION, Queenstown, Maryland 21658. Telephones: 301-827-7166 or 301-827-7160.

WANTED: General practitioners, anesthesiologist, urologist, obstetrician, orthopedist and pediatrician needed in growing community of 15,000. Service area 25,000. Present 83-bed general hospital. New 100+ bed automated hospital to be completed within two years. City has excellent industry, school system, and recreational activities. 45 minutes from Madison or Milwaukee. Future unusually promising. For more information contact: Administrator, Watertown Memorial Hospital, Watertown, Wis.

WANTED: In a college community, an associate or partner for a large medical practice. No surgery or OB. General practice can be done if desired. X-ray and laboratory facilities in the office. If desired, will consider sale. Write Box 344, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

OFFICE FOR RENT: August 5, 1968 and thereafter. Call 924-6261, 1815 N. Capitol, Indianapolis.

PHYSICIAN needed for occupational health service. Career opportunity or part time. Previous industrial experience not required. Plant has comprehensive medical program of preemployment, health maintenance, and emergency room care. Salary negotiable. Write or phone Dr. William Woodward, Gary Steel Works, U. S. Steel Corporation, Gary, Indiana 46402.

EMERGENCY ROOM PHYSICIAN: Excellent opportunity for young physician interested in full-time practice of emergency room care. Join a physician group responsible for the emergency service of two major Cincinnati hospitals. Remuneration on a fee-for-service basis with guaranteed minimum. Must have or be eligible for Ohio license. Send resume to P. O. Box 36163, Cincinnati, Ohio 45236.

ANESTHESIOLOGIST: Solo, fee-for-service, board qualified. Any area considered. Also interested in inhalation therapy consultation, therapeutic and diagnostic blocks. Only offers of interest answered. Write Box 349, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

SEVENTEEN-MAN Wisconsin group located in college community of 40,000 with excellent hospital facilities is seeking additional associates in the following areas:

1. Internal Medicine
2. Urology
3. General Surgery
4. General Practice

For further information, please contact D. R. Griffith, M.D., Midelfart Clinic, Eau Claire, Wis. 54701.

FOR SALE OR LEASE: 1,100 sq. ft., new building, fully carpeted, space for additional office bldg. on the property; reception room, 4 treatment rooms, laboratory, private business office, 2 rest rooms. Adjacent to new St. Vincent's Hospital on 86th St. Write Roger A. Carroll, D.D.S., 709 E. Main St., Brownsburg or call 852-2976.

FOR SALE: Full size Picker x-ray machine with fluoroscope and screen—$1,500. Write Dr. E. T. Gaddy, 2602 W. Washington St., Indianapolis, or phone 636-5871.

OPENING for pathologist, psychiatrist and general practitioner (preferably with psychiatric or geriatric experience). 1651-bed general medical-surgical and psychiatric hospital with excellent facilities and progressive staff; an equal opportunity employer. Salary: $13,507.00 through $23,921.00 according to training and experience. Write to Director, VAH, Danville, Illinois 61832.

NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

Charges for commercial announcements are:

First four lines: $3.00
each additional line: 50¢

Send cash with order. Average count: seven words to the line.

DEADLINE: Fifth day of month PRECEDING month of issue.

ADVERTISERS IN THIS ISSUE

July 1968 Volume 61 No. 7

Abbott Laboratories 991-95
Associated Credit Bureaus of Indiana 1031
Breon Laboratories, Inc. 979
Brown Pharmaceutical Co. 1012
Burroughs Wellcome & Co., Inc. 1043
Campbell Soup Company 1015
Dorsey Laboratories 961-64
Geigy Pharmaceuticals 970-71, 1044-48
Glenbrook Laboratories 1020
Hanger, J. E., Inc. 1059
Harding Hospital 999
Home Lawn Mineral Springs 1060
Hook's Drugs 1033
Hynson, Westcott & Dunning, Inc. 953
Indiana Medical Bureau 978
Lederle Laboratories 955, 965, 976-77, 1052, 1063
Lilly, Eli & Company 980, 1018-19
Medical Protective Co. of Ft. Wayne 1066
Mutual Medical Insurance, Inc. .....3rd Cover
Pitman-Moore Company 983
Poythress, Wm. P. & Co., Inc. 1054
Robins, A. H. Company, Inc. .....2nd Cover
Roche Laboratories .....4th Cover, 1039
Searle, G. D. & Co. 1016-17
Strasenburgh Laboratories.....1022
Stuart Company, The 1021
Tutag, S. J. & Company 1053
Wabash Valley Hospital 969
Warren-Teed Pharmaceuticals 973-74
White-Haines Optical Co. 957
Wyeth Laboratories 1027

In accepting advertising for publication, *The Journal* has exercised reasonable precaution to insure that only reputable factual advertisements are included. However, we do not have facilities to make any comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services, and medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertiser only. Neither sanction nor endorsement of such is warranted, stated, or implied by the association.

J-O-P
Univ Of Calif
Med Ctr Library
Acquisitions Dept
San Francisco, Calif 94122
J-O-C
12-68

Vol. 61 • No. 8
August, 1968

GENERAL PRACTITIONERS' ISSUE

JOURNAL
OF THE INDIANA STATE
MEDICAL ASSOCIATION
Indianapolis, Indiana

I hereby certify that the Bearer M.
Henry Sooley has been Studying the Prac
of Physick, and Surgery near eight years
under my direction, and that by the assistan
of a good genius, and close attention he ha
made great progress in both studies. —
Since my acquaintance with him he has
conducted himself with the strictest mora
rectitude free from the least whisper of
scandal, and I recommend him as a good Membe
of society to all who may take notice of
him. —

New Bern
Sept. 23d 1793. —

U.C. MEDICAL CENTER LIBRARY
SEP 4 1968
San Francisco 94122

Coming home is wonderful

when you have Blue Cross-Blue Shield

After a long hospital stay, coming home is wonderful—if you have let Blue Cross–Blue Shield do the worrying for you about health care bills.

Blue Cross—Blue Shield provides generous benefits at the hospital, makes realistic allowances to your doctor. And in these days of excellent, but expensive, health care, that's more important than ever.

Employers prefer Blue Cross–Blue Shield, too. They have no admission or claims forms to worry about—they're not running a branch office for some health insurer. All paperwork is handled directly between Blue Cross–Blue Shield and hospital and doctor.

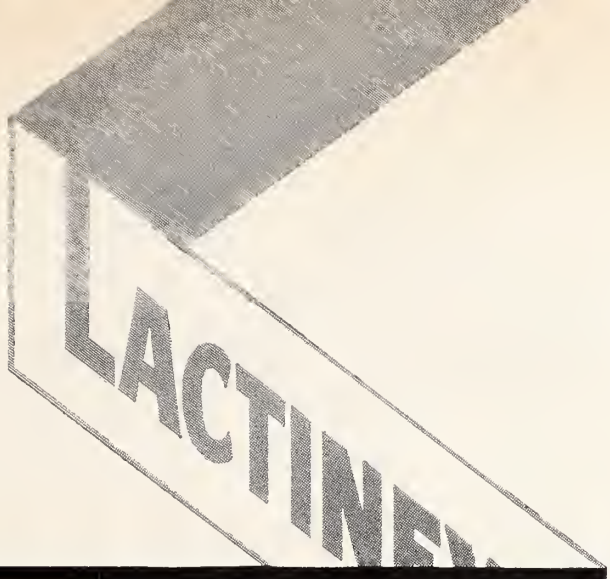
Yes, coming home is wonderful when you have Blue Cross–Blue Shield. For you, because it was a worry-free homecoming—for your employer because your claim was processed so efficiently he probably didn't even know about it.

That's why people say—from the heart—"**I don't know what we would have done without Blue Cross–Blue Shield.**"

Blue Cross-Blue Shield

MUTUAL HOSPITAL INSURANCE, INC. MUTUAL MEDICAL INSURANCE, INC.
HOME OFFICE: 110 N. ILLINOIS ST., INDIANAPOLIS, INDIANA 46204

(One of a series of ads being run in key Hoosier newspapers)



LACTINEX®

TABLETS & GRANULES

■ **to help restore and stabilize the intestinal flora**

■ **for fever blisters and canker sores of herpetic origin**

LACTINEX contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

First introduced to help restore the flora of the intestinal tract in infants and adults,[1, 2, 3, 4] LACTINEX has also been shown to be useful in the treatment of fever blisters and canker sores of herpetic origin.[5, 6, 7, 8]

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

HYNSON, WESTCOTT & DUNNING, INC.

BALTIMORE, MARYLAND 21201

(LX04)

LX
LX
LX

AUGUST 1968

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Office of Publication

3935 N. Meridian, Indianapolis, Indiana 46208

Contents

SCIENTIFIC

Effective Office Management of Obesity, George S. Allen, M.D., Georgetown 1101
Six Years of Newborn PKU Screening, Paul H. Martin, M.D., Elkhart 1107
Five Year's Experience with Dymelor, Jack W. Hickman, M.D., William R. Kirtley, M.D., Indianapolis 1114
Treatment of Epilepsy, Joseph B. Green, M.D., Indianapolis 1118
What Constitutes Legal Death, John C. Green, B.S., Greenwood 1120
Drug-Induced Blood Dyscrasias, Wei-Ping Loh, M.D., Gary 1125
Electrocardiogram of the Month, Charles Fisch, M.D., Indianapolis 1133
X-Ray Conference: Aneurysm of the Abdominal Aorta, Erich K. Lang, M.D., Shreveport, La. 1134
Fractures and Orthopedic Problems: The Fingertip Injury — An Evaluation of Treatment, James W. Strickland, M.D., Indianapolis 1136

EDITORIALS

Are We Well Fed? Who Knows? 1142
Two Mailings 1142
"a Disese cald Milksick," W. D. Snively, Jr., M.D., Evansville 1143
Venereal Disease Problem, A. L. Marshall, Jr., M.D., Indianapolis 1144
Nation of the Physically Unfit, V. L. Nicholson, President's Council on Physical Fitness and Sports 1144
Editorial Notes 1144

SPECIAL FEATURES

The Tiny Flaws in Medical Design Can Kill, Ronald Gechman, West Coast Editor, Electronic Design, New York, New York 1151
Report on Actions of the House of Delegates, AMA 117th Annual Convention, June 16-20, 1968. 1156

REGULAR FEATURES

What's New? 1093
Month in Washington 1096
From The Journal 50 Years Ago 1119
President's Page 1146
The Woman's Auxiliary Reports to ISMA 1148
Gleaned from the British Medical Journal, Jack W. Hickman, M.D., Indianapolis ... 1154
Medical Panorama: Thanatology Resurrected, A. W. Cavins, M.D., Terre Haute 1159
Medicine at Law 1160
Abstracts, Book Reviews 1163
Blue Cross and Blue Shield Return Most in Benefits (One of a Series) 1166
Wanted: Locations, Physicians 1166
News Notes 1169
Board of Health Report 1174
Annual Meeting Dates of Professional Medical and Allied Organizations 1175
Future Meetings, Seminars, Courses 1176
Deaths 1177

BUSINESS

Executive Committee:
May 18, 1968 1178
June 8, 1968 1179
The Council:
June 9, 1968 1180

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 46202. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

Representative for national advertising is the State Medical Journal Advertising Bureau, 510 N. Dearborn St., Chicago, Ill.

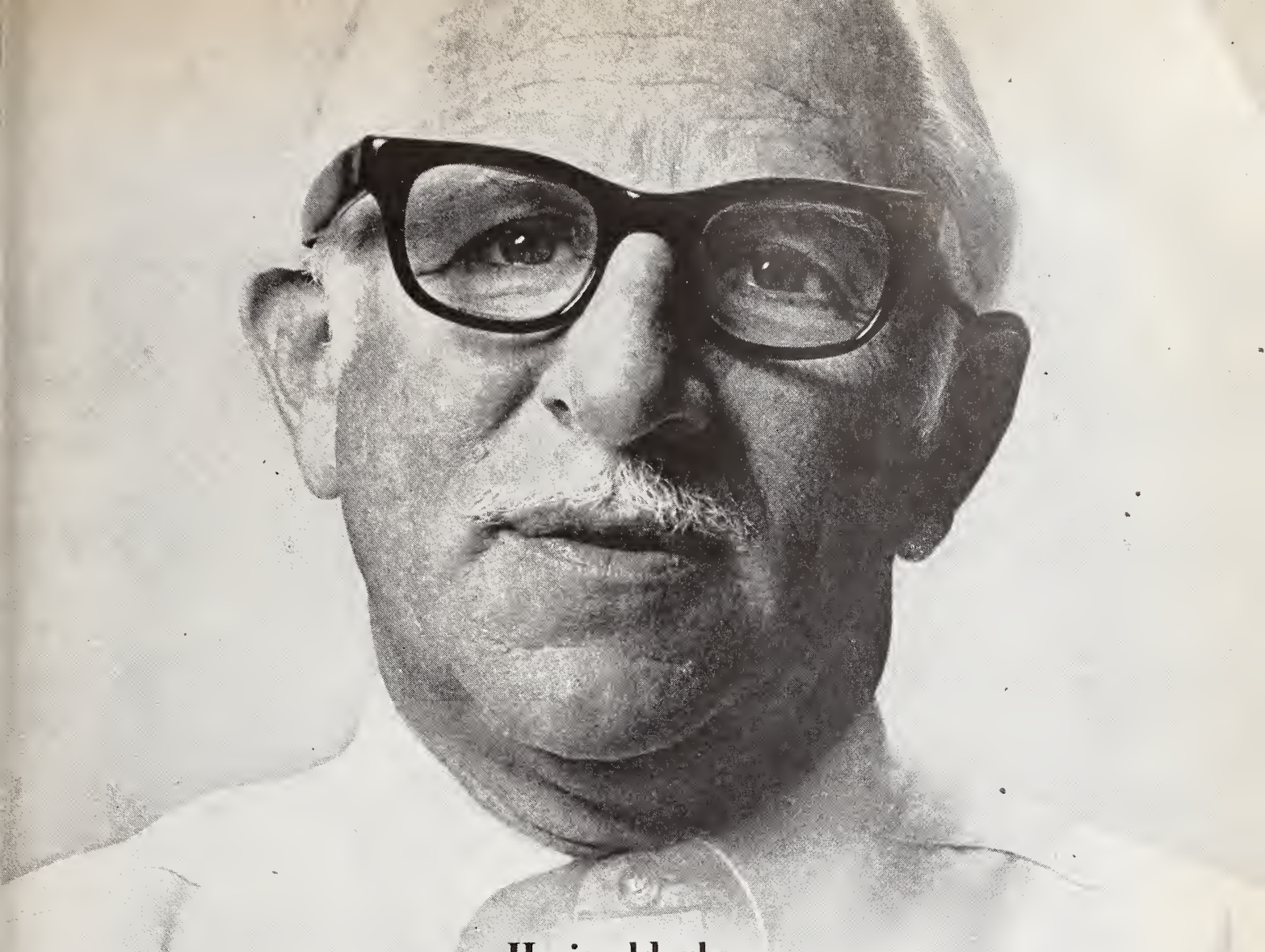
Entered as second class matter January 25, 1933, at the Postoffice at Indianapolis, Indiana. Copyright, 1968 by the Indiana State Medical Association. Published monthly at 3935 N. Meridian, Indianapolis 46208.

Second-class postage paid at Indianapolis, Indiana and at additional mailing office.

All issues of 1967 and subsequently may be obtained on microfilm. Address The Journal for details.

About Our Cover

on page 1108.



He is elderly.
He is on corticosteroids.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg
and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545

ANNUAL CONVENTION—OCTOBER 15-18, 1968—FORT WAYNE

OFFICERS FOR 1967-68

President—G. O. Larson, M.D., 1110 Indiana Ave., LaPorte 46350.

President-Elect—Patrick J. V. Corcaran, 3700 Bellemeade, Evansville 47715.

Treasurer—Lester H. Hoyt, M.D., Methodist Hospital, Indianapolis 46207.

Assistant Treasurer—Malcolm O. Scamahorn, Pittsboro 46167.

Executive Secretary—Mr. James A. Waggener, 3935 N. Meridian, Indianapolis 46208.

COUNCILORS

District	Term Expires
1—Gilbert M. Wilhelmus, Evansville	Oct. 1968
2—Joe Dukes, Dugger	Oct. 1969
3—Donald M. Kerr, Bedford	Oct. 1970
4—Rabert M. Reid, Columbus	Oct. 1968
5—Wilbert McIntosh, Riley	Oct. 1969
6—Stephen D. Smith, Knightstown	Oct. 1970
7—Albert M. Donato, Indianapolis	Oct. 1968
8—Donald R. Taylor, Muncie	Oct. 1969
9—Peter R. Petrich, Attica	Oct. 1970
10—Lowell H. Steen, Whiting (Chairman)	Oct. 1968
11—Lowell Hillis, Logansport	Oct. 1969
12—William R. Clark, Fort Wayne	Oct. 1970
13—Otis R. Bowen, Bremen	Oct. 1968

ALTERNATE COUNCILORS

District	Term Expires
1—Eugene Austin, Evansville	1970
2—Betty Dukes, Dugger	1968
3—Elmer L. Wallace, New Albany	1968
4—Jack E. Shields, Brownstown	1970
5—Cleon M. Schauwecker, Greencastle	1970
6—Frank Green, Rushville	1969
7—John O. Butler, Indianapolis	1969
8—Paul Sparks, Winchester	1970
9—Clarence G. Kern, Lebanon	1968
10—Herman Wing, Gary	1969
11—James A. Harshman, Kokomo	1968
12—Frederic L. Schoen, Fort Wayne	1970
13—George B. Gattman, Elkhart	1970

SECTION OFFICERS 1967-68

Section on Surgery:
Chairman—Donald M. Schlegel, Indianapolis
Vice-chairman—Henry Larzelere, Marion
Secretary—Austin Gardner, Indianapolis

Section on Internal Medicine:
Chairman—I. E. Michael, Indianapolis
Vice-chairman—Louis Sandock, South Bend
Secretary—Robert L. Rudesill, Indianapolis

Section on Ophthalmology and Otolaryngology:
Chairman—David E. Brown, Indianapalis
Vice-chairman—Kenneth F. Isenogle, Fort Wayne
Secretary—George A. Clark, Indianapolis

Section on Anesthesiology:
Chairman—William M. Matthews, Indianapolis
Vice-chairman—Merle E. Pickett, Fort Wayne
Secretary—Jerry R. Miller, Indianapolis

Section on General Practice:
Chairman—Jay S. Reese, Martinsville
Vice-chairman—Robert Mouser, Indianapolis
Secretary—Richard Juergens, Fort Wayne

Section on Obstetrics and Gynecology:
Chairman—Robert M. Reid, Columbus
Vice-chairman—Tom W. Wachob, Jr., Kokomo
Secretary—Charles R. Echt, Indianapolis

Section on Public Health and Preventive Medicine:
Chairman—Donald M. Kerr, Bedford
Vice-chairman—T. Neal Petry, Delphi
Secretary—Henry G. Nester, Indianapolis

Section on Radiology:
Chairman—John A. Robb, Indianapolis
Vice-chairman—Robert E. Beck, Evansville
Secretary—Dale B. Parshall, Elkhart

Section on Nervous and Mental Diseases.
Chairman—Gordon T. Brown, Indianapolis
Vice-chairman—James E. Benson, Elkhart
Secretary—Wesley A. Kissel, Indianapolis

Section on Pathology:
Chairman— Robert J. Frost, Michigan City
Vice-chairman—Frank Vellios, Indianapolis
Secretary—Robert L. Costin, Indianapolis

Section on Pediatrics:
Chairman—Roland E. Miller, Lafayette
Vice-chairman—Gustaf W. Erickson, South Bend
Secretary—Morris Green, Indianapolis

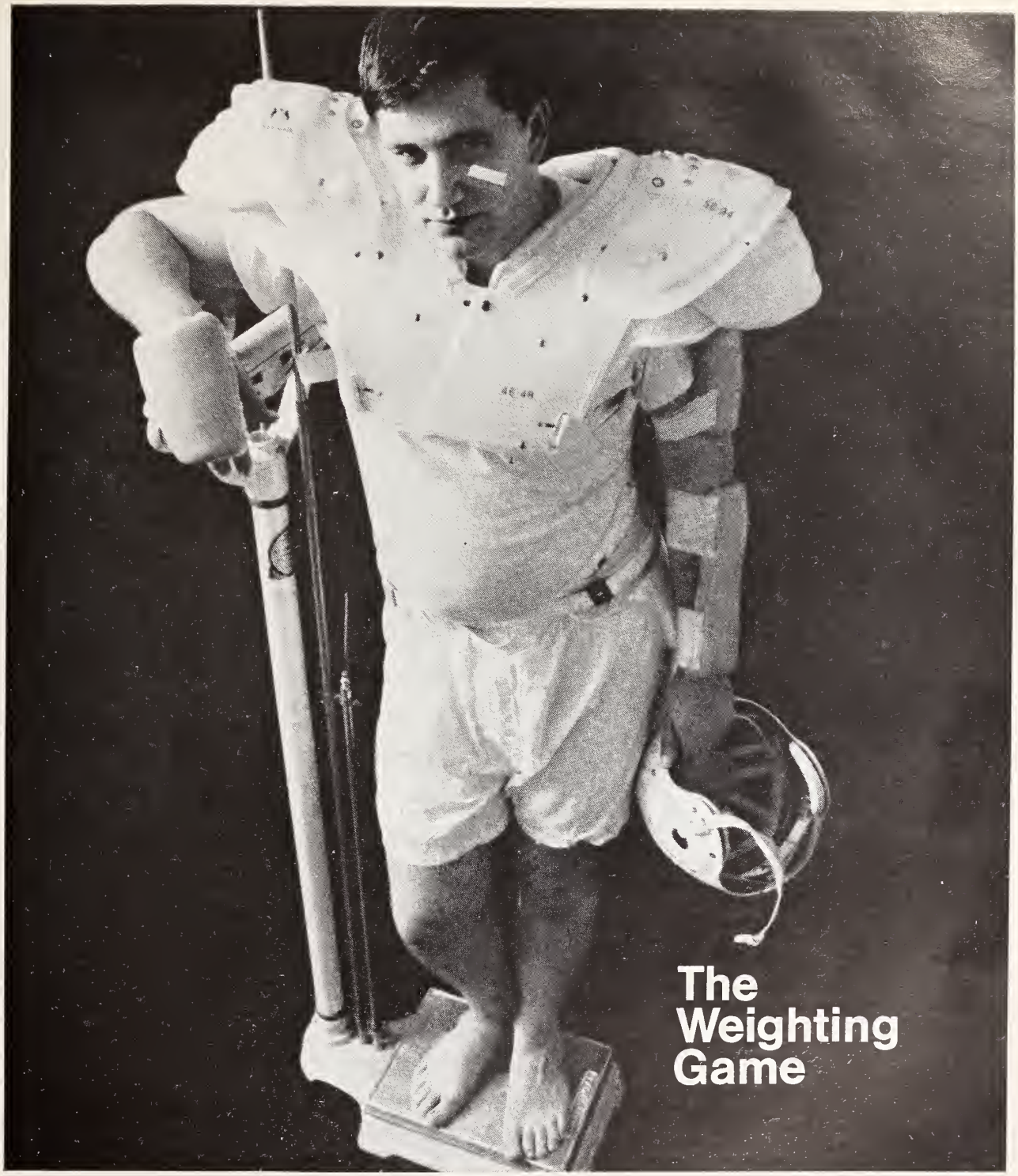
DELEGATES TO THE AMA

Terms expire December 31, 1968:

Delegates	Alternates
Harold C. Ochsner Indianapolis	Don E. Wood Indianapolis
Eugene F. Senseny Fort Wayne	Robert M. Brown Marion
Frank H. Green Rushville	Kenneth O. Neumann Lafayette

Terms expire December 31, 1969:

Delegates	Alternates
Guy A. Owsley Hartford City	Maurice E. Glock Fort Wayne
Jack E. Shields Brownstown	Dwight W. Schuster Indianapolis



Too often athletes take off too much too soon. They're using fad stuff and crash diets.

They don't seem to realize that a speed-up in reducing can cause a slow-down in producing.

In the long run, there's really no fast way.

Losing weight is a growing problem. Here's where you, the professional, can help. Educate. Inform. Explain to parents and team members the risks involved with quickie solutions. Tell them about a planned program of diet, exercise, proper rest and will power.

Project Weight Watch can help, too. We have a complete portfolio of materials and suggested diets available, free. The diets are a realistic balance of the 4 food groups—meat, breads and cereals, fruits and vegetables and dairy foods. The kind of diets you'd probably suggest yourself. It'll only take a minute to send for them.

PROJECT WEIGHT WATCH
FACTS, NOT FADS

Plan a losing strategy today.

Name _____

Position _____

Address _____

City _____

State _____ Zip _____

DAIRY COUNCILS OF INDIANA

EVANSVILLE - INDIANAPOLIS - SOUTH BEND
50 SOUTH PARKER, INDIANAPOLIS 46201

COUNTY MEDICAL SOCIETY DIRECTORY

COUNTY	PRESIDENT	SECRETARY
Adams	Arthur H. Girod, Decatur	Harold F. Zwick, 227 S. Second St., Decatur
Allen (Fort Wayne)	Frederic L. Schoen, Fort Wayne	Eugene E. Schmidt, Suite 725, Indiana Bank Bldg., Fort Wayne
		Mr. Larry L. Pickering, Exec. Secy., 212 Med. Ctr. Bldg., Fort Wayne
Bartholomew-Brown	Harold W. Richmond, Columbus	C. David Ryan, 2600 Sandcrest Blvd., Columbus
Benton	A. L. Coddens, Earl Park	D. L. McKinney, Box 398, Otterbein
Boone	James R. McAfee, Lebanon	Katherine A. Jackson, 95 E. Oak St., Zionsville
Carroll	Marilyn L. Wagoner, Burlington	Robert Seese, 101 W. North St., Delphi
Cass	Joseph S. Bean, Logansport	Edward L. TerBush, 216 Ninth Street, Logansport
Clark	Robert K. McKechnie, Jeffersonville	Hassi Shina, Charlestown
Clay	J. Frank Maurer, Brazil	Forrest R. Buell, 314 Lankford St., Clay City
Clinton	Bruce A. Work, Frankfort	George K. Hammersley, 361 E. Clinton St., Frankfort
Daviess-Martin	A. G. Blazey, Washington	Hamlin B. Lindsay, 511 E. Main St., Washington
Dearborn-Ohio	Fred D. Houston, Lawrenceburg	Leslie M. Baker, 501 Fourth St., Aurora
Decatur	Dale D. Dickson, Greensburg	Arnold D. Ducanes, 215 N. Franklin St., Greensburg
DeKalb	John C. Harvey, Auburn	C. Bishop Hathaway, 209 N. Jackson St., Auburn
Delaware-Blackford	Glynn A. Rivers, Muncie	Richard N. Philbert, 2810 Ethel Ave., Muncie
Dubois	John P. Salb, Jasper	Edward Ploetner, 111-115 Central Bldg., Jasper
Elkhart	Philip G. Bowser, Goshen	Page E. Spray, 320 W. High St., Elkhart
Fayette-Franklin	B. W. Sanders, Connersville	J. L. Steinem, 818 Grand Ave., Connersville
Floyd	James Y. McCullough, New Albany	Daniel H. Cannon, 1201 E. Spring St., New Albany
Fountain-Warren	Max N. Hoffman, Covington	Theodore Person, 601 N. Mill St., Veedersburg
Fulton	Joseph D. Richardson, Rochester	F. Richard Walton, 116 W. 9th St., Rochester
Gibson	William E. Dye, Oakland City	David H. Lindauer, 115 N. Prince St., Princeton
Grant	J. C. Jarrett, Marion	Robert G. Young, 1207 Northwood Ct., Marion
Greene	Robert Moses, Worthington	Harry Rotman, Jasonville
Hamilton	John S. Hash, Noblesville	H. R. Blackburn, Riverview Hospital, Noblesville
Hancock	John J. Farrell, Greenfield	Joseph A. Miller, Oaklandon
Harrison-Crawford	Carl Dillman, Corydon	Richard A. Jordan, Corydon
Hendricks	Eli Coats, Indianapolis	Carl J. Heinlein, 637 E. Main, Danville
Henry	John E. Fisher, New Castle	Phyllis Grant, 3007 S. 14th St., New Castle
Howard	Robert L. Michael, Kokomo	J. F. Doss, 3520 Lafountain, Kokomo
Huntington	Barth E. Wheeler, Huntington	Carl S. Ray, Warren
Jackson-Jennings	Kenneth E. Bobb, Seymour	William F. Blaisdell, 207 N. Pine, Seymour
Jasper	Ernest R. Beaver, Rensselaer	Francis E. O'Brien, McKinley and Washington Sts., Rensselaer
Jay	Ralph Steffy, Portland	Elizabeth Tate, 317 S. Main St., Dunkirk
Jefferson-Switzerland	Elton Heaton, Madison	Ott B. McAtee, Madison State Hospital, Madison
Johnson	George Brown, Greenwood	Charles Link, 365 E. Main St., Greenwood
Knox	Boyd K. Black, Vincennes	John S. Murray, 317 Security Bank Bldg., Vincennes
Kosciusko	Wymond B. Wilson, Mentone	Arthur L. Moser, 600 Winona, Warsaw
LaGrange	Michael O. Mellinger, LaGrange	Allen S. Martin, Box 3A, Shipshewana
Lake	Seymour W. Shapiro, Gary	Reginald R. Barton, 7737 Forrest Ave., Gary
		Mr. John B. Twyman, Ex. Dir., 4640 W. 5th Ave., Gary
LaPorte	William E. Wolf, LaPorte	James J. J. Sprecher, 1001 Maple Ave., LaPorte
		Mrs. Polly Dent, Exec. Dir., 903 Indiana Ave., LaPorte
Lawrence	George W. Sorrells, Bedford	Reid C. Crosby, 11 Saddler Ct., Bedford
Madison	John R. Wagoner, Anderson	William M. Stinson, 333 Jackson St., Anderson
Marion	Dwight W. Schuster, Indianapolis	John O. Butler, 234 E. Southern Ave., Indianapolis
		Mr. Arthur G. Loftin, Exec. Secy., 211 N. Delaware St., Indianapolis
Marshall	John K. Guild, Plymouth	M. George Rosero, Kewanna
Miami	Parker W. Snyder, Peru	Gordon S. Crates, Denver
Montgomery	V. G. Viray, Crawfordsville	W. E. Shannon, 408 W. Market St., Crawfordsville
Morgan	George Ostheimer, Martinsville	Maurice A. Turner, 10½ N. Main St., Martinsville
Newton	John Parker, Goodland	Arthur Schoonveld, Brook
Noble	O. Thomas Slough, Kendallville	Joseph Greenlee, Avilla
Orange	Charles X. McCalla, Paoli	Phillip T. Hodgin, Orleans
Owen-Monroe	Brad Bomba, Bloomington	Philip R. Karsell, 3901 E. 3rd St., Bloomington
Parke-Vermillion	John Somerville, Clinton	Milton Herzberg, Clinton
Perry	Robert Gilbert, Tell City	Gene E. Ress, 507 Main St., Tell City
Pike	M. H. Omstead, Petersburg	M. H. Omstead, Petersburg
Porter	John E. Read, Chesterton	Milton R. Carlson, 14000 Central, Portage
Posey	Paul Boren, Poseyville	Herman Hirsch, 130 W. 5th St., Mt. Vernon
Pulaski	Henry R. Eshelman, Monterey	E. L. Hollenberg, 613 Tippecanoe Dr., Winamac
Putnam	James B. Johnson, Greencastle	Anne S. Nichols, 707 E. Seminary, Greencastle
Randolph	Howard W. Koch, Winchester	Paul W. Sparks, 214 S. Main St., Winchester
Ripley	Bill E. Freeland, Batesville	William J. Warn, Milan
Rush	Donald I. Dean, Rushville	Charles E. Sheets, Manilla
St. Joseph	Jacob Rosenwasser, Mishawaka	L. F. Sandock, 503 Sherland Bldg., South Bend
		Mr. Harry Davis, Exec. Secy., 106 W. Monroe, South Bend
Scott	Ignacio B. Castro, Shelbyville	Jesus C. Bacala, 69 Wardell St., Scottsburg
Shelby	P. M. Inlow, Shelbyville	R. P. Inlow, 103 W. Washington St., Shelbyville
Spencer	John C. Glackman, Jr., Rockport	Michael O. Monar, Rockport
Starke	Earl Leinbach, Hamlet	W. Allen Palmer, Knox
Steuben	Mary H. Cameron, Angola	Richard W. Artz, 416 E. Maumee St., Angola
Sullivan	Glen McClure, Sullivan	J. S. Brown, Carlisle
Tippecanoe	L. H. Wagner, Lafayette	Chester L. Waits, 49 N. 26th St., Lafayette
Tipton	Robert L. Haller, Kempton	Albert E. Stouder, Kempton
Vanderburgh	Ralph Carlson, Evansville	Mr. Arthur P. Tiernan, Exec. Secy., 109½ S. E. 3rd., Evansville
Vigo	John Freed, Terre Haute	Robert L. Meissel, 920 N. 19th St., Terre Haute
Wabash	Fred C. Poehler, LaFontaine	Frank Smyrniotis, 645 Spring St., Wabash
Warrick	Peter B. Hoover, Boonville	Robert C. Colvin, Newburgh
Washington	Eddie R. Apple, Salem	Truman L. Chastain, 906 W. Mulberry, Salem
Wayne-Union	John Stepleton, Richmond	John Dehner, Reid Memorial Hospital, Richmond
Wells	Charles Caylor, Bluffton	R. D. Willard, R. R. 4, Bluffton
White	W. M. Dickerson, Monticello	M. Ali Jehanyar, 116 N. Illinois, Monticello
Whitley	Verlin P. Huffman, S. Whitley	Thomas Hamilton, 115 S. Main St., Columbia City

Diagnostic Products Sales, The Dow Chemical Company, Midland, Michigan 48640.

You won't have to wait for these results to come back from the lab. Because now you can do blood chemistry tests in your own office. With Diagnostest* reagents and instruments. You get accurate, precise results in minutes. And we teach your nurse or medical assistant to do the tests. The system can be used to measure hemoglobin, glucose, cholesterol, urea nitrogen, total bilirubin and uric acid. Write today for full details

*Trade mark of The Dow

DOW

ISMA Committees and Commissions for 1967–1968

COMMITTEES

Executive
Ralph V. Everly, Indianapolis, chairman; Burton E. Kintner, Elkhart; G. O. Larson, LaPorte, President; Patrick J. V. Corcoran, Evansville, President-Elect; Lowell H. Steen, Whiting, Chairman of the Council; Lester H. Hoyt, Indianapolis, Treasurer; Malcolm O. Scamahorn, Pittsboro, Assistant Treasurer.

Grievance
Philip B. Reed, Indianapolis, chairman; Eugene S. Rifner, Van Buren, vice-chairman; Robert G. Young, Marion, secretary; Kenneth L. Olson, South Bend, Earl W. Mericle, Indianapolis; Richard Bloomer, Rockville; John M. Paris, New Albany; Wilson L. Dalton, Shelbyville; William R. Noe, Bedford.

Student Loan
G. O. Larson, LaPorte; Lester H. Hoyt, Indianapolis; Glenn W. Irwin, Indianapolis; Donald R. Taylor, Muncie; James O. Ritchey, Indianapolis; Lester D. Bibler, Indianapolis; Mr. Robert Robinson, Indianapolis.

Medical-Legal Review
Lall G. Montgomery, Muncie; Truman E. Caylor, Bluffton; E Rogers Smith, Indianapolis

COMMISSIONS

Aging
George M. Young, Gary, Chairman; A. W. Cavins, Terre Haute, Vice-Chairman; Raymond Duncan, Bedford, Secretary; Bernard B. Rosenblatt, Evansville; R. E. Buckingham, Bloomington; Walter S. Fisher, Columbus; Glen A. Ramsdell, Richmond; John O. Butler, Indianapolis; John Cullison, Muncie; Wallace R. Van Den Bosch, Lafayette; George W. Wagoner, Delphi; Nathan Salon, Fort Wayne; Donald T. Olson, South Bend; Andrew C. Offutt, Indianapolis; Wendell C. Anderson, Indianapolis.

Constitution and Bylaws
Gordon S. Fessler, Rising Sun, Chairman; William M. Sholty, Lafayette, Vice-Chairman; James F. Lewis, Liberty, Secretary; George W. Willison, Evansville; Thomas H. Gootee, Jasper; M. C. Topping, Terre Haute; Joseph F. Ferrara, Franklin; B. D. Wagoner, Union City; Chester L. Waits, Lafayette; O. L. Marks, East Chicago; Richard L. Glendening, Logansport; John S. Farquhar, Fort Wayne; Edwin C. Mueller, La Porte; Burton Kintner, Elkhart.

Convention Arrangements
Charles H. Aust, Fort Wayne, Chairman; Durward W. Paris, Kokomo, Vice-Chairman; William M. Kendrick, Mooresville, Secretary; Richard B. Hovda, Evansville; William F. Howard, Bloomington; Irvin Sonne, New Albany; Merritt O. Alcorn, Madison; John E. Freed, Jr., Terre Haute; John Mader, Richmond; Francis E. Stout, Muncie; Boyd A. Burkhardt, Tipton; John L. Ferry, Whiting; James D. Finfrock, Elkhart; Kenneth Kohlstaedt, Indianapolis; Charles Fisch, Indianapolis.

Governmental Medical Services
Charles Hendrix, Vincennes; Guy H. Waldo, Bedford; Herman Echsner, Columbus; Dick J. Steele, Greencastle; Tom S. Shields, Richmond; Robert P. Scott, Indianapolis; J. F. Hinchman, Parker; Ramon B. Dubois, Lafayette; Edward J. Dierolf, Gary; George D. Buckner, Fort Wayne; D. D. Swihart, Elkhart; Jerome E. Holman, Jr., Indianapolis; Glen V. Ryan, Indianapolis.

Inter-Professional Relations
Fred Flora, Frankfort, Chairman; Virgil E. Angel, Highland, Vice-Chairman; William S. Robertson, Spiceland, Secretary; A. Wayne Ratcliffe, Evansville; Philip R. Karsell, Bloomington; Charles X. McCalla, Paoli; John W. Ripley, Seymour; Richard L. Veach, Bainbridge; Willis W. Stogsdill, Indianapolis; Wendell Covalt, Muncie; H. H. Dunham, Wabash; Pierre C. Talbert, Bluffton; A. Alan Fischer, Indianapolis; Robert G. Husted, Munster.

Legislation
Dwight W. Schuster, Indianapolis, Chairman; Don E. Wood, Indianapolis, Vice-Chairman; Jack W. Hickman, Indianapolis, Secretary; Daniel M. Hare, Evansville; Harold Manifold, Bloomington; Elmer L. Wallace, New Albany; Leslie M. Baker, Aurora; Fred W. Dierdorf, Terre Haute; John Davis, Flat Rock; Guy A. Owsley, Hartford City; Max N. Hoffman, Covington; Daniel Ramker, Hammond; Lester Renbarger, Marion; Eugene F. Senseny, Fort Wayne; Otis R. Bowen, Bremen.

Medical Economics and Insurance
Thomas G. Hamilton, Columbia City, Chairman; Thomas J. Conway, Terre Haute, Vice-Chairman; Chester A. Stayton, Jr., Indianapolis, Secretary; Charles M. Sinn, Evansville; Paul W. Holtzman, Bloomington; Edward J. Ploetner, Jasper; William A. Johnson, North Vernon; David R. Cain, New Castle; James M. Leffel, Indianapolis; Charles E. Geckler, Muncie; Kenneth O. Neumann, Lafayette; A. S. Kobak, Valparaiso; Richard Wagner, Huntington; Jack W. Hannah, Elkhart; William J. Miller, Lafayette.

Medical Education and Licensure
James B. Johnson, Greencastle, Chairman; John L. Cullison, Muncie, Vice-Chairman; Forrest LaFollette, Hammond, Secretary, John Sterne, Evansville; Betty Dukes, Dugger; John M. Paris, New Albany; Richard A. Snapp, Columbus; Frank Coble, Richmond; George T. Lukemeyer, Indianapolis; William Ringer, Williamsport; Leo Radigan, Gary; Lowell J. Hillis, Logansport; Joel Salon, Fort Wayne; Jene R. Bennett, South Bend; Merritt O. Alcorn, Madison; Peter J. Pilecki, Michigan City; Glenn W. Irwin, Jr., Indianapolis.

Public Health
T. O. Middleton, Bloomington, Chairman; Henry G. Nester, Indianapolis, Secretary; Daniel Hare, Evansville; Roy L. Fultz, Salem; R. M. Seibel, Nashville; Cleon M. Schauwecker, Greencastle; Wilson L. Dalton, Shelbyville; Stanley W. Burwell, Muncie; Theodore C. Person, Veedersburg; Gilbert Z. Given, East Chicago; Paul Sparks, Winchester; Theodore J. Smith, Whiting; Bertram Roth, Indianapolis; Charles H. Rushmore, Indianapolis, consultant.

Public Information
Frederic L. Schoen, Fort Wayne, Chairman; William B. Challman, Evansville, Vice-Chairman; William G. Moore, La Porte, Secretary; Louis Blessinger, Corydon; Herman J. Echsner, Columbus; William G. Bannon, Terre Haute; Robert D. Spindler, Shelbyville; Robert W. Harger, Indianapolis; Don W. Boyer, Lebanon; Thomas C. Chael, Munster; Fred C. Poehler, La Fontaine; Louis F. Sandock, South Bend; Loren H. Martin, Indianapolis.

Special Activities
Marvin E. Priddy, Fort Wayne, Chairman; Robert M. Brown, Marion, Vice-Chairman; Norbert M. Welch, Vincennes; Robert O. Zink, Madison; John E. Freed, Jr., Terre Haute; Harold C. Ochsner, Indianapolis; Henry Bibler, Muncie; Clarence G. Kern, Lebanon; Adolph Walker, East Chicago; K. G. Hill, New Castle.

Voluntary Health Agencies
Norman R. Booher, Indianapolis, Chairman; James H. Gosman, Indianapolis, Vice-Chairman; M. O. Scamahorn, Pittsboro, Secretary; Albert Ritz, Evansville; Ed R. Cantwell, Vincennes; T. A. Neathamer, Scottsburg; Harry R. Baxter, Seymour; William G. Bannon, Terre Haute; Wayne Endicott, Greenfield; William A. Karsell, Indianapolis; James S. Fitzpatrick, Portland; Albert E. Applegate, Frankfort; John G. Kolettis, Gary; Lloyd L. Hill, Peru; Richard Willard, Bluffton; Frank McCue, Michigan City.

Future Planning Committee
Earl W. Mericle, Indianapolis, chairman; Maurice E. Glock Fort Wayne; James S. Fitzpatrick, Portland; A. Wayne Ratcliffe, Evansville; Fred S. Carter, LaPorte; William B. Challman, Mount Vernon; James E. Wenger, Nappanee; Charles F. Gillespie, Indianapolis; Leslie M. Baker, Aurora, (Ex-Officio Members)—Patrick J. V. Corcoran, Evansville; G. O. Larson, La Porte; Lowell H. Steen, Whiting; Ralph V. Everly, Indianapolis; Frank B. Ramsey, Indianapolis.

1967-68 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	R. E. Weitzel, Princeton	Fred Smith, Tell City	
2.	Brad Bomba, Bloomington	J. S. Brown, Carlisle	
3.	Daniel H. Cannon, New Albany	Elmer L. Wallace, New Albany	April 2, 1969, New Albany
4.	Bill E. Freeland, Batesville	William J. Warn, Milan	
5.	Jack Somerville, Clinton	Milton Herzberg, Clinton	
6.	Stephen Smith, Knightstown	David Wynegar, Richmond	
7.	John O. Butler, Indianapolis	Donald E. Stephens, Indianapolis	
8.	F. E. Stout, Muncie	Richard N. Philbert, Muncie	June 4, 1969, Muncie
9.	Martin Dickerson, Monticello	M. Ali Jehanyar, Monticello	May 22, 1969, Lafayette
10.	John J. Reed, Hobart	Raymond Doherty, Crown Point	
11.	Charles Wise, Camden	Fred Poehler, La Fontaine	September 18, 1968, Delphi
12.	Kenneth F. Isenogle, Fort Wayne	John J. Hartman, Angola	May 21, 1969, Fort Wayne
13.	E. C. Mueller, LaPorte	John Hildebrand, South Bend	September 11, 1968

In peptic ulcer: the antacid puzzle

solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O. K.?"

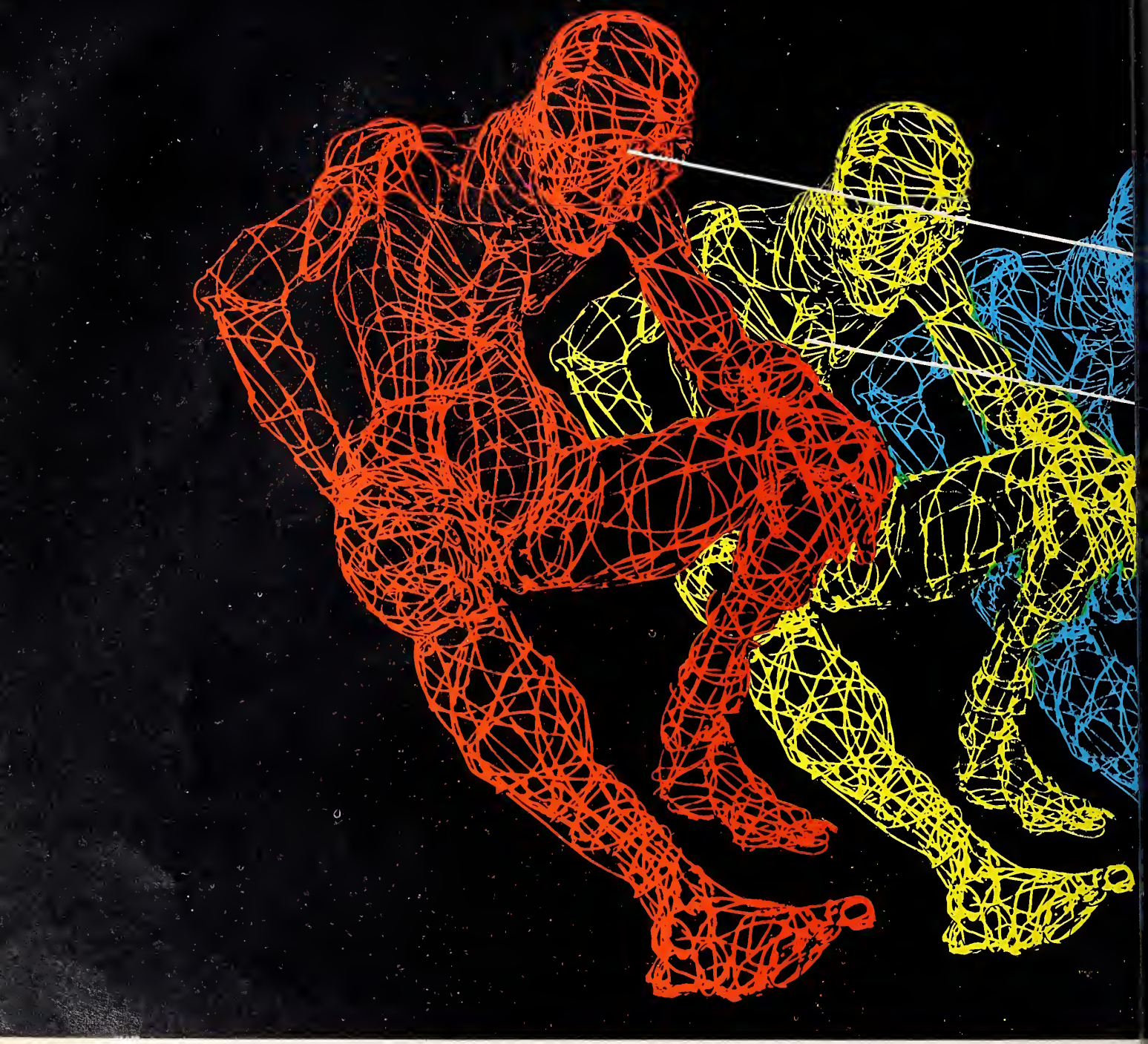
The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart

Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150 mg.
Cobalamin Concentrate, N.F., equivalent to **Cobalamin** (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	**7.5 mcg.**
Iron, Elemental (as Ferrous Fumarate)	110 mg.
Ascorbic Acid (Vitamin C)	75 mg.
Folic Acid	1 mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequate vitamin B_{12} therapy may result in hematologic remission but neurological progression. Adequate doses of vitamin B_{12} (parenteral or oral with potent intrinsic factor as in Trinsicon® [hematinic concentrate with intrinsic factor, Lilly]) usually prevent, halt, or improve the neurological changes.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potentiation of absorption of physiological doses of vitamin B_{12}. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B_{12}, may be necessary. No single regimen fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Periodic

You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500. [032568]

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206.

801668

Lilly

choose an experienced candidate—
millions of doses prescribed

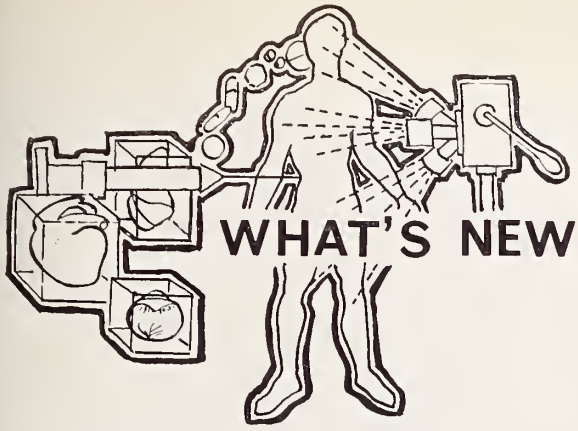
Benadryl®
(diphenhydramine hydrochloride)

The White band on Pink capsule combination is a registered trademark of Parke, Davis & Company.

Supplied in various dosage forms including Kapseals®, containing 50 mg. of diphenhydramine hydrochloride.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS



WHAT'S NEW?

"Establishing a Volunteer Department in a Rehabilitation Center", a new 54-page booklet, was published by the New York University Medical Center to assist directors and administrators. It is illustrated and covers in detail the organization and administration of the volunteer component. Copies are $2.50 each. Write Institute of Rehabilitation Medicine, 400 E. 34th St., New York City 10016.

* * *

Psychoactive drugs are presented in an historical background, which goes back to prehistoric tribal rites and carries up to the psychedelic "rites" of today by a publication of the National Institute of Mental Health. The 450-page book contains the proceedings of a symposium held in San Francisco under the sponsorship of the Psychopharmacology Research Branch. Public Health Service Publication No. 1645 is available for $4.00 from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402.

* * *

A new micro-surgery instrumentation system suspends from the operating room ceiling and eliminates tubing, wiring and other accessories from the floor area. The new module includes a precision microscope with motorized focusing device and zoom lens, irrigating equipment, an electrocautery, and a Draeger high vacuum erisiphake. There are three adjustable high intensity light beams and a rotatable slit lamp for ophthalmic surgery. The control system includes controls for anesthesia equipment and a cryoextractor as well as low voltage for three other ophthalmic instruments. A vertical swivel arm holds two instrument trays. A movable surgeon's chair with built-in foot controls enables the surgeon to operate most of the accessories by remote control. The system was developed by Drs. Sautter and Draeger of Hamburg, Germany, and is distributed in the U. S. by Edward Weck & Company of New York City.

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments, and surgical appliances and book publishers. Each item is published as news and does not necessarily constitute an indorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Tandearil® in Osteoarthritis
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.
Warning: Tandearil is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.
Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.
Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reacti-

"Pain Break" for an osteoarthritic.

Tandearil can usually ease it.

At 46, her knees still look good on the outside. But inside, there may be the familiar picture of osteoarthritis.

If aspirin doesn't help, Tandearil often will. Pain and stiffness begin to ease up in 3 or 4 days. You can often maintain response with a daily dose of only 1 or 2 tablets.

Of course, Tandearil is not for every osteoarthritic. Select your patients carefully and follow them in line with the Contraindications, Precautions, Warning, and Adverse Reactions listed below.

But for many aspirin-stubborn osteoarthritics, let Tandearil ease the unwelcome pain breaks of osteoarthritis.

Tandearil®
oxyphenbutazone

vate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis) or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity, angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

For complete details, please see full Prescribing Information.

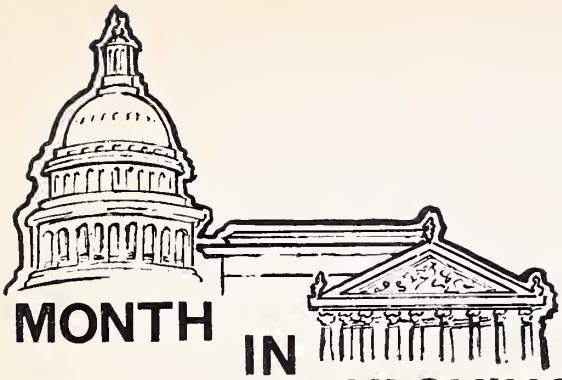
Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily. In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and other factors influencing drug response
Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000

Geigy

(B) 46-800 A

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

TA-6806AR



MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

WASHINGTON, D.C.—President Johnson designated the Secretary of Health, Education and Welfare, Wilbur J. Cohen, as the chief federal official for health policies and programs.

AN HEW reorganization plan, recommended by Cohen and approved by Mr. Johnson, makes the secretary:
1). The President's chief adviser on federal health policy and programs.
2). Responsible for coordinating all federal health programs.
3). Head of a new Federal Interdepartmental Health Policy Council.

THE REORGANIZATION also included creation of a Consumer Protection and Environmental Health Service as a unit of the Public Health Service and transfer of the Division of Regional Medical Programs from the National Institutes of Health to the Health Services and Mental Health Administration.

MR. JOHNSON also agreed to renew a request to Congress to raise the status of HEW's principal health official, now Dr. Philip R. Lee, from assistant secretary to Under Secretary for Health and Science.

THE NEW CONSUMER and environmental health unit consists of:
—The Food and Drug Administration;
—The National Center for Air Pollution Control;
—The National Center for Radiological Health;
—The National Center for Urban and Industrial Health;
—Certain staff units of the Office of the Director, Bureau of Disease Prevention and Environmental Control.

CHARLES C. JOHNSON, JR., a negro and Assistant Commissioner for Health for Environmental Health in New York City, was named to head the new unit. An engineer, he had been on leave from the Public Health Service and his new post makes him the highest ranking negro member in the history of PHS.

DR. HERBERT L. LEY, JR., who had been director of the FDA's Bureau of Medicine since the fall of 1966, was appointed to succeed Dr. James L. Goddard who recently resigned as Commissioner of Food and Drugs. Dr. Ley, 44, had been recommended by Goddard and also had the support of a number of Senate and House members on committees concerned with FDA. A 1946 graduate of the Harvard Medical School, Dr. Ley had been on the faculty at his alma mater and the George Washington University School of

Medicine earlier in his career. He also had served as chief of medical branches of the Army research office and the office of the Army Surgeon General.

THE INTERDEPARTMENTAL health policy council will oversee all federal activities in the health field, such as the drafting of physicians for service with the armed forces, Veterans Administration hospitals and Office of Economic Opportunity health projects.

COHEN SAID that there had been no way in the past for the HEW secretary to give guidance in such matters. He said there must be a reexamination of the drafting of physicians to provide care in the United States for civilian dependents of military personnel.

"THIS ALLOCATION of a portion of the critically scarce physician pool materially affects programs intended to make health care as widely available as possible, a national health goal that goes far beyond the mission of the Department of Defense," Cohen said.

AS MEDICARE went into its third year, Cohen announced the appointment of a 12-member advisory council to study the possible extension of the program to disabled persons under age 65. Congress last year turned down the Administration's request for such an extension but authorized creation of the council to study the matter.

IN DISCUSSING MEDICARE, Cohen said rising health care costs had made financing of the program a serious problem. He said new financing, presumably a tax increase, may be required if costs continue to rise.

"PHYSICIANS must act with restraint on fees or people will ask government to put on controls, "he said. "I would not like to see that."

DR. HENRY H. KESSLER, director of the Kessler Institute for Rehabilitation in Newark, N.J., was named chairman of the advisory council. Other members are:

DR. MORRIS BRAND, medical director of the Sidney Hillman Health Center; James Brindle, president of the Health Insurance Plan of Greater New York; James M. Gillen, director of personnel research of General Motors; Juanita Kreps, associate professor of economics at Duke University; Dr. Leonard W. Larson, past president of the American Medical Assn.; Daniel W. Pattengill, vice president of Aetna Life and Casualty Co.; Bert Seidman, director of the AFL-CIO social security department; E. A. Vaughn, vice president of the Aluminum Co. of America; Anthony G. Weinlein, executive assistant to the president of the AFL-CIO Building Service Employees; E. B. Whitten, executive Director of the National Rehabilitation Assn., and Dr. Alonzo S. Yerby, professor at Harvard's School of Public Health.

AMA SUPPORTS MOST OF BILLS PROVISIONS

THE AMERICAN MEDICAL Association told Congress it supported most provisions of the Administration's health manpower bill as essential to increasing enrollment in the nation's medical schools.

THE AMA POSITION was outlined by Dr. William A. Sodeman of the AMA's Council on Medical Education in testimony before the House Public

Continued

Health and Welfare Subcommittee. He noted that a recent joint statement of the AMA and the Association of American Medical Colleges that more funds from both government and private sources would be needed by medical schools if they were to expand enrollment.

"THE BILL (H. R. 15757) before the subcommittee provides a means of furnishing the Federal component of the necessary financial resources," Dr. Sodeman said.

IN OTHER TESTIMONY, the AMA supported the overall objectives of the Administration's occupational health bill. But the Association opposed a provision that would authorize establishment and enforcement of mandatory national standards for health and safety.

DR. R. LOMAX WELLS, chairman of the AMA's Council on Occupational Health, told a Senate Labor Subcommittee, that the objectives of the bill (S. 2864) could "best be accomplished through the research, education and straining provisions and through grants to states to enable them to undertake and conduct more effective programs in both occupational health and safety."

URGING REJECTION of the mandatory standards provision, Dr. Wells said that this authority has been "properly vested in the states where the standards and the enforcement can be adapted to their particular geographical and industrial conditions."

SUPREME COURT REFUSES TO RULE AGAINST PUBLIC DRUNKENNESS

THE U.S. SUPREME COURT refused, by a 5-4 division, to lay down a constitutional rule against punishing chronic alcoholics for being drunk in public.

IN AN OPINION by Justice Thurgood Marshall, four members of the Court said that neither the facts of the test case nor "the comparatively primitive state" of scientific knowledge on the subject justifies such a decision at present.

THE VOTE of the four, plus Justice Byron R. White, who concurred separately, upheld the conviction of Leroy Powell, 67, who was fined $50 in a Travis County, Tex., court for being drunk in public.

THE ARGUMENT for Powell was that alcoholism is a disease and the person suffering from it should be treated rather than punished.

TWO AMA AUTHORITIES on alcoholism expressed surprise and disappointment at the court's decision. Dr. Marvin Block of Buffalo, N.Y., a member and former chairman of the AMA's Committee on Alcoholism and Drug Abuse, and Dr. Dana L. Farnsworth of Harvard University, chairman of the AMA Council on Mental Health took issue with the court opinion that "we are unable to conclude . . . that chronic alcoholics in general . . . suffer from such an irresistible compulsion to drink and get drunk in public that they are utterly unable to control their performance . . . ." ◄

Dear Doctor:

Wouldn't you like your patients to learn more about the contributions made by the world of medicine to their welfare? So that they can better appreciate the efforts of the health team to keep them in good health?

To tell the stories of medical and pharmaceutical advances to people throughout the country, the Pharmaceutical Manufacturers Association is sponsoring a unique "magazine within a magazine." It is called *Medicines and your family's health* and the first issue appears in the November *Reader's Digest*.

We would like to send you 50 free reprints of *Medicines and your family's health* for use in your reception room. Your patients will find the articles in this issue factual, educational and of immediate personal interest.

Just fill out the coupon below and send it to us.

Order Desk
Pharmaceutical Manufacturers Association
1155 Fifteenth St., N.W.
Washington, D. C. 20005

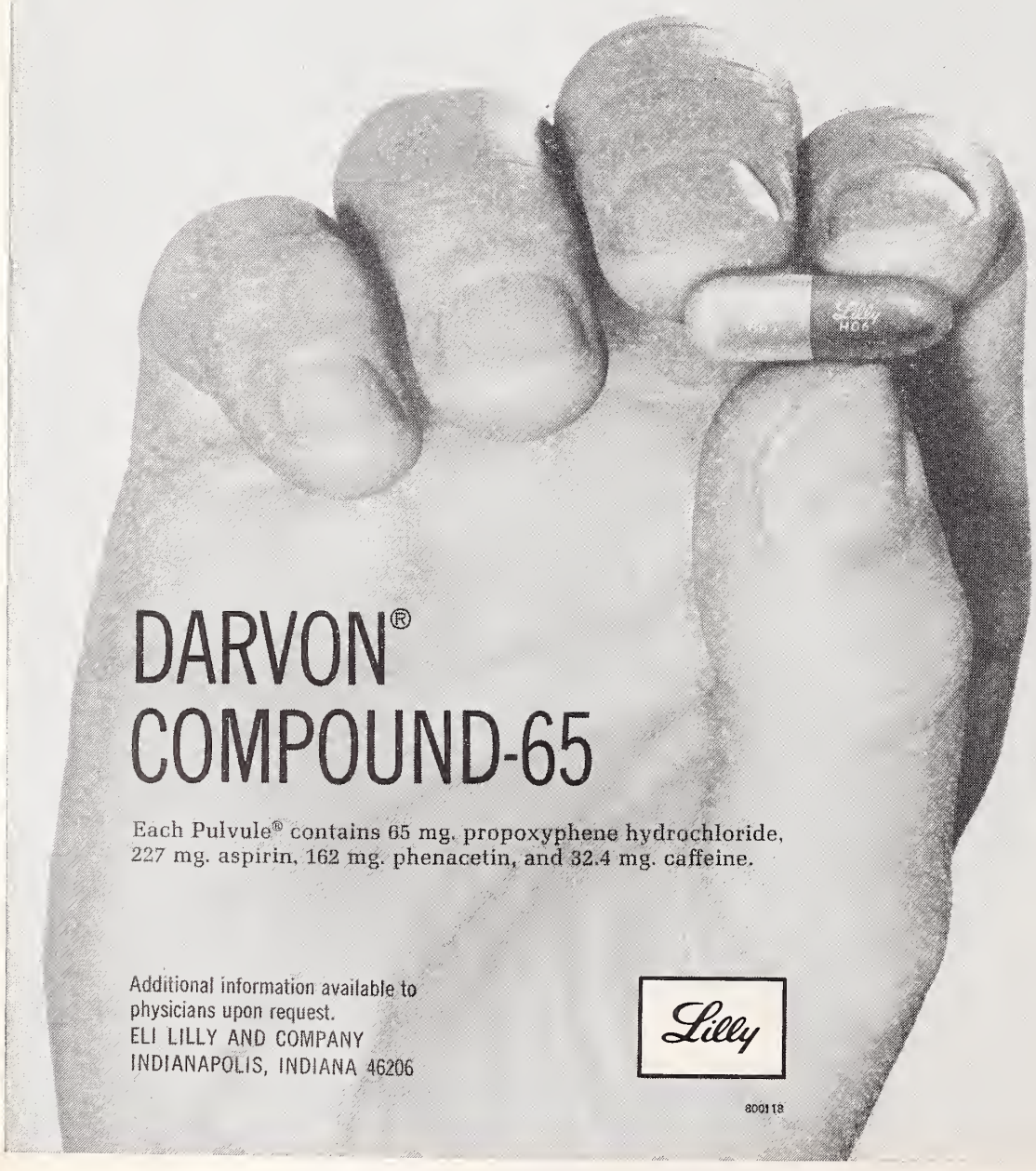
Gentlemen:
Please send me 50 free copies of
Medicines and your family's health.

Name_____

Street_____

City_____ State_____ Zip_____

Part of the fine art of medicine



DARVON® COMPOUND-65

Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.

Additional information available to physicians upon request.
ELI LILLY AND COMPANY
INDIANAPOLIS, INDIANA 46206

Lilly

806118

The Journal of the INDIANA STATE MEDICAL ASSOCIATION
Supervised by THE COUNCIL
Volume 61 — August 1968 — Number 8

The treatment of obesity from psychologic, dietary and anorexigenic bases is considered. The epidemiologic factors are discussed; the clinical results are tabulated.

Effective Office Management of Obesity

GEORGE S. ALLEN, M.D.
Georgetown

ONE doesn't have to digest the entire literature dealing with obesity: He has but to make a reasonable beginning and he will soon come to a few basic conclusions:

(1) It is abundantly clear that we doctors do not know all there is to know about obesity. The literature is fat with studies, therapies and theories. The fat patient's organs, organic systems and psyche have been carefully scrutinized from every angle and to date the magic cure hasn't appeared.

(2) Fat persons are fat because they eat too much.[1] Many weird abnormalities of metabolism can occur, but fat can no more come from nothing than can any other material. And the fat patient has this simple truth to accept if he is to have any chance at all to find a "cure."

(3) Obesity, as pointed out by Cyril MacBryde,[1] "is a symptom which, because of its implications and consequences, commands the medical consideration accorded serious disease." Casual examination of insurance statistics is sufficient to underscore this point.

(4) Fat persons are subject to the same illnesses as other individuals—usually more so. They are complete individuals—not just protoplasm, or organs on feet, or freaks—and they are usually unhappy. The myth of the jolly fat person is just that—a myth.

(5) There is no magic in the treatment of obesity—only hard, painstaking work for both the doctor and the patient. Moreover, the long-range results of obesity treatment are extremely discouraging.

The Physician's Attitude

This brings us to a primary consideration—the physician who attends to the obese patient. The physician, in my opinion, should not attempt to treat the obese patient unless he is genuinely interested and willing to expend the effort and time needed to manage the program properly. The situation of a fat person going to a physician for help and receiving about five minutes of the doctor's time, a drug firm-furnished, 1,000-calorie diet, and a prescription for "diet" pills, and being told to return in two, three, or four weeks, is the cornerstone of treatment failure.

Assuming, therefore, that the doctor isn't bored with obese patients and does truly want to afford such patients a successful management, we can next consider the patient. Certainly, all fat persons are not alike; nonetheless, certain subtle common denominators prevail.

The Obese Patient

Obviously, all fat patients have too much adipose tissue—the result of a positive caloric balance. There is usually a history of obesity in siblings and/or parents. But primarily, an overwhelming percentage of obese patients eat not only too much, but improperly. Many of them eat no breakfast and little lunch, but consume a high-caloric evening meal, followed by snacks until bedtime. Most fat persons are extremely impatient: they believe in and want a magical solution, hoping to find a way to eat themselves back to normalcy. Practically all of the diet fads and fantasies offer the poor, gullible magic-seeking fat person a way to fill his mouth and grow thin [illegible]

appeal to his already excessive orality.

These traits amalgamate to form the composite obese personality. The desire for magic, the impatience, and the orality simply add up to a peculiar emotional defect or lack of development. It is a sort of childishness that is characterized by abnormal dependency needs. The fat patient may camouflage beautifully, but if one looks carefully he will find this excessive dependency. There must be a fundamental understanding of the obese dependency if an overall success is to be achieved.

Pharmacotherapy

Any stringent program required for effective weight reduction demands the use of anorexigenic medication. Of the many useful agents available, none seems to serve the single purpose of curbing appetite better than dextroamphetamine; but the drug's characteristic CNS stimulatory side effects act as deterrents toward its use for many patients. Such untoward effects as insomnia and jitteriness account for a large percentage of the obese patients who discontinue therapy prematurely.[2] When it is combined with meprobamate, however, the effects of excessive stimulation are counteracted for the most part.[3-6] The sustained-release form of this combination *(meprobamate 300 mg. + dextroamphetamine sulfate 15 mg.)** was used in this study. A single capsule daily suppressed hunger throughout the hours of usual food intake. The value of this anorexigenesis, lasting through mealtimes and between-meal "danger" periods, is obvious in view of the psychological factors with which the overall therapy must cope.[3,7]

Thus this report concerns a study of the clinical management of obesity, applying the principles outlined above. A rigid diet was enforced, both for actual weight reduction and for psychologic effect, with the use of a meprobamate-dextroamphetamine combination to curb appetite.

* Appetrol—S. R., Wallace Pharmaceuticals, Cranbury, New Jersey.

Method

Fifty obese patients provided the population for this study. Selection was random, except that no patients under 12 years of age or less than 15% overweight* were admitted to the study. The 40 women and 10 men ranged from 12 to 62 years of age (average: 35.2 years). Percentages overweight ranged from 15.4 to 87.0% (average: 34.7%). The primary diagnosis of 37 patients was exogenous obesity; in the remaining patients obesity was a concomitant to such organic conditions as hypertension, hormonal imbalance and pregnancy.

Each of the 50 patients underwent complete physical evaluation, including basic laboratory studies and chest films, at the outset of treatment. This examination served two purposes: First, it would reveal any findings which might contraindicate the therapeutic regimen; second, it provided a subtle form of financial motivation. The "advance payment" for the physical workup required at the start of therapy often supplemented the patient's initial impetus to lose weight with the urge to get his money's worth. Moreover, the author advised the patient that each weekly office visit during the treatment period would be free of charge—but *only* when urine tests showed ketone formation, thus evidencing faithful adherence to the prescribed diet.

Following the physical examination, the required diet was handwritten personally for each patient. Although the diet was the same in each case, the actual task of prescription was performed in this way as another offering to the patient's individuality. The diet used (Figure 1) is a modified version of the regimen proposed by Simeons.[8] Its unusual severity, in allowing only two daily meals, was likewise designed to reemphasize the importance of weight reduction and thereby to increase motivation.

* Ideal weights and percentages overweight were calculated on the basis of the standard insurance height-weight chart.

Without some sort of a "crutch," the highly restrictive, almost punitive, diet would hardly be tolerable for the average patient. The combination of meprobamate 300 mg. and dextroamphetamine sulfate 15 mg., in sustained-release capsule form was added to the regimen to provide the help necessary to inhibit appetite. Patients were instructed to take one capsule daily, approximately 12 hours before anticipated bedtime. A small degree of suggestion may have been at work here. The patients were told simply that the prolonged effects of the drug would help them to adhere to the diet by curbing their appetite.

Likewise, for the sake of motivation, each patient was told to anticipate a *six-week* program. I do not think the ordinary obese patient can lose weight too fast. The overwhelming majority of them are peculiarly infantile—they want results, but *fast.* The more rapid the weight loss, the more apt they are to persist in their efforts. (The time-honored approach to weight reduction aims at an average loss of about one pound per week. The theory behind this method is fine; in fact, it rarely works. The failures lie with the impatience typical of most obese patients. The infrequent successes probably result from a dominance of the physician's personality.)

The role that psychotherapy played in this study seems worth a brief mention. The obese patient's typical dependency was encouraged and accepted *at first,* thus promoting early development of the goal of *physician approval.* During the course of subsequent weekly visits, the orientation of the major goal was gradually directed toward one of *self-approval.* At the initial office visit, each subject was told firmly that he could expect no magical formula for losing weight. Each was given just one guarantee;

he *would* lose weight, but only if he adhered rigidly to the prescribed dietary discipline.

Aside from the anorexigenic agent, diuretics were the only drugs used with any frequency during this study. It is well known that obese patients do not lose weight smoothly. Plateaus occur, and are frequently a cause of discouragement and frustration for the typically impatient obese person. In this study, oral or parenteral diuretics were given for short periods to 24 "plateaued" patients to restore motivation through the impetus of a gratuitous loss of three or four pounds. After this was achieved the diuretics usually were stopped and the diet and anorexigenic agent continued.

Results

Weight Loss: This dietary and anorexigenic regimen effected an average reduction of just under 20 lbs. (range: 7.5 lbs. gain to 49.5 lbs. loss) among the 50 subjects (Table 1). This reflects a reduction from the pretherapy average of 35% overweight to an average of 20% overweight after therapy. The majority of the subjects (34) lost between 10 and 30 lbs., for study periods ranging from 1 to 21 weeks. Looking at the results another way, there was a total of *976 lbs.* lost among the 50 patients over the course of 2,557 patient-days in study—or an average loss per day of 0.381 lbs.

While six patients quit the study prematurely—within the first three weeks of therapy (one because of an apparent drug reaction)—over half of the subjects remained available to follow-up for the full six-week program. Eighteen patients, with an average weight loss of 21 pounds, did not return after five weeks in the study. Six were sufficiently motivated to extend the course of treatment by as much as five to 15 weeks, with an average weight loss of 31.5 pounds.

Two subjects were pregnant at the time of their inclusion in this study.

TWO-MEAL-A-DAY DIET

MEAL #1

Meat
Vegetable
½ slice dry toast
Beverage

MEAL #2

Meat
Vegetable
*Salad
½ slice dry toast
Beverage

MEATS

Allowable Items		Preparation
Beef:	Steak Roast	(1) Cut off all visible fat (2) Serving = 4 oz. cooked (3) Cook by:
Poultry:	Chicken Turkey	A. Broiling B. Baking C. Frying without fat, oil, or grease in a Teflon skillet
(Bake only)		
Seafood:	Fish Lobster Shrimp	

VEGETABLES

Asparagus
Broccoli
Brussels sprouts
Cauliflower
Cabbage
Celery
French style green beans
Greens of all kinds
Tomatoes
Mushrooms
Lettuce

(1) Serving = 1 cup, cooked
(2) Cook by:

A. Boiling
B. Steaming

* Salad Dressing: Choice of vinegar, lemon juice, or 2 tsp. diet-type salad dressings.

BEVERAGES

You may have as much of the following as you desire:

Water)
Coffee) (no milk, cream, milk/cream substitute, or sugar;
Tea) you may use artificial sweeteners)
Diet-type soft drinks

SNACKS

Twice a day you may select any one item as a snack from the list below:

4 pieces celery
6 radishes
1 dill pickle
1 wedge raw cabbage
1 medium raw tomato
½ grapefruit
1 medium apple
1 medium orange

FIGURE 1

One of these patients remained on the present regimen for 21 weeks during pregnancy. During the first six weeks of treatment, in her second trimester, she reduced from 243 to 225 lbs.; she continued in therapy, and had actually *lost* an additional half-pound 15 weeks later, just prior to normal delivery of a completely normal son. The anorexic effect produced by the test medication was excellent, averaging 14 hours.

The other pregnant subject started the present regimen near the end of her second trimester. During the fifth week of therapy—when she had reduced from 161.5 to 153 lbs.—the patient quit the study, due to her father's death. In the following four weeks (entering her final trimester), the patient regained the weight she had lost; she then returned to the diet and anorexic medication for one week more and lost four lbs. Anorexic effect was quite satisfactory. Overall response was only fair; the patient could have lost more weight, had the treatment course been uninterrupted. Her delivery and infant were entirely normal.

Other Effects of Drug Therapy: Only three patients complained of untoward effects possibly attributable to drug treatment: Dry mouth, weakness, and nervousness reported simultaneously by one patient; insomnia and jitteriness by another patient; and insomnia alone. Only the first of these three complaints appeared well founded.

The primary *psychological* effect of this treatment was an improved outlook and attitude, which became apparent in 37 of the 50 patients. After the study ended some obese patients, who began to regain a few pounds, returned to ask for another prescription for the drug to help them get back to their diet. The patient acceptance after medication can therefore be considered quite adequate.

Correlation of Overall Response and Anorexia

Final evaluation of the overall results of therapy (Table 2) indicated *good* to *excellent* responses in 36 of the 50 patients (72%). Two of the six treatment failures appeared closely bound to insuperable psychoneurotic needs to eat without restraint. Another patient discontinued therapy because of a complaint of insomnia, which likewise appeared more closely related to a psychoneurotic condition than to the medication. Each of the three remaining patients responding poorly to the present regimen had been on intensive weight-reduction programs just prior to this program.

The results generally bear out what is common knowledge: that a long history of obesity and repeated thwarted attempts at weight reduction carry a poor prognosis. Excellent results were recorded for 20 of the 31 patients (65%) in this, their first systematic attempt to lose weight, but in only 21% of the 19 patients who had been on weight reduction programs previously. Moreover, weight loss was significantly greater ($P<0.05$) in the 25 patients who had been obese less than 10 years compared to those with a history of obesity which exceeded this period.

Classification of overall responses is compared in Table 2 to a tally of anorexic effectiveness. Although the two criteria yielded roughly similar breakdowns of the subjects' responses, there were some significant differences. Of the 23 patients (46%) reporting excellent anorexia from drug treatment, five were evaluated as only fair to good overall responses. Also, one of the 16 patients experiencing a very satisfactory anorexic effect was considered as an overall treatment failure; and appetite was curbed in at least two of the other five treatment failures. These poor responses despite adequate anorexigeneses only serve to emphasize the extremely compulsive nature of the eating habits of some persons. Although admitting they were not hungry, these patients had to eat to excess, with, of course, resultant failure to lose weight.

The average duration of anorexia for 45 patients (the other five could not make a reasonable estimate) was 13 hours. Appetite inhibition lasting 10 hours, reported by one patient, was the shortest duration of anorexic effect in this study. The medication's appetite-suppressing action appeared still in effect to some significant degree even longer than 13 or 14 hours in a considerable number of cases. Almost every subject, having taken a single dose of the drug at about 10 A.M., reported their loss of appetite continued through the time of the evening meal and usually suf-

DISTRIBUTION OF WEIGHT LOSSES OVER A FOUR-MONTH PERIOD

Pounds Lost	Number of Patients	Percent of Patients
0-10	7	14%
10-19	16	32
20-29	18	36
30-39	6	12
40-50	1	4
(Gain: 7.5)	1	2
(Mean Loss: 19.85 lbs.)	50	100%

TABLE 1

ficiently past this hour to suppress the urge for pre-bedtime snacks.

Case Histories

The treatment of obesity in the present study is represented by the following detailed case histories:

Case #3: A 58-year-old high school principal had been overweight for more than 15 years when first seen. He had steadily gained about 30 lbs. in that time to reach his present weight of 225 lbs., 31.8% overweight. Past medical history was noncontributory. All the male members of his family were obese. Personal history disclosed that the patient was single, lived at home and did not drink or smoke. He attributed his overweight to eating three fairly heavy meals each day with an excessive intake of "cokes" between meals. He had not made any previous serious attempts to lose weight.

Except for the weight problem, multiple benign skin nevi and some exertional dyspnea, the patient appeared healthy (B.P. 136/80) and remarkably stable emotionally. Treatment for exogenous obesity with Appetrol-S.R. and diet without other concomitant therapy was begun. After seven weeks of therapy, a weight loss of 26.5 lbs. convinced the patient to remain on the treatment schedule for another six weeks, when he reached a plateau of 193.5 lbs. The patient lost 31 lbs. in 14 weeks of therapy, a reduction from 31.8% to 15.8% overweight.

Anorexic effect was quite satisfactory, lasting for about 11 hours; no adverse effects attended the use of either the medication or the stringent diet. The patient expressed great satisfaction with his weight loss. The excellent overall response helped to change his attitude from certainty that he could never lose weight, before therapy was instituted, to one of serious weight consciousness when the formal study ended.

This patient, seen almost one year later, had maintained his reduced weight by returning to the diet and anorexic agent whenever he began to notice a tendency for his weight to increase. The ultimate resolution of this man's weight problem was one of the most gratifying ones in the present series.

OVERALL THERAPEUTIC RESPONSE AND ANOREXIC EFFE

Overall Response	Patients Number	Percent	Anorexic Effect	...tients ...nber	Percent
Excellent	24	48%	Excellent	23	46%
Good	12	24	Very satisfac...	16	32
Fair	8	16	Satisfactor...	6	12
Poor	6	12	Not de...mined	5	10

TABLE 2

Case #7: A 26-year-old woman came to me with complaints of being overweight, and of marked tension and anxiety which she associated with her responsibility of caring for her husband's retarded daughter by a previous marriage. Both of the patient's parents were excessively overweight. The patient had been married for three years, and had gained 66 lbs. in that time to reach her present weight of 218 lbs.; she admitted eating very heavily at supper and between meals, calling this habit a response to her nervousness. She had not undertaken any concrete weight-reduction program in the past.

Exogenous obesity appeared directly related to a typical anxiety syndrome. Therapy for obesity with diet and Appetrol-S.R. was instituted with intermittent use of diuretics. The patient lost 34 lbs. in six weeks of therapy, and was motivated to continue reducing. She had lost another 13 lbs. 13 weeks after the start of treatment. Her weight had decreased to 171 lbs.—a reduction from 74% to 37% overweight. Anorexic effect was excellent, lasting for at least 14 hours; the patient noted definite improvement in her mood, and increased energy. Overall response was excellent.

She has continued on this regimen; in the week following her final examination in this study, she lost another five lbs. At a recent follow-up observation, her weight was noted to have decreased remarkably to a fairly stable level of 138 lbs. Thus, she had adhered to the diet and had continued to take meprobamate combined with amphetamine for about 13 months; over this period she had lost a total of 80 lbs., attaining almost the ideal weight for her height and body frame. Most important is the fact that this patient has satisfactorily changed her eating habits.

Summary

Obesity must be regarded as a psychological, as well as physical, condition of serious nature. Realization of the abnormal dependency characteristic of the "obese personality" leads to principles of clinical management entailing a rather severe dietary regimen. This necessity leads in turn to the need for effective but safe anorexigenic medication. It is felt that this study of 50 obese patients has demonstrated the value of combining 15 mg. dextroamphetamine sulfate with 300 mg. meprobamate in sustained-release form to satisfy the prerequisites of an effective anorexigenic agent, namely: (1) Prolonged, satisfactory appetite suppression; (2) Minimal side effects.

The overall responses of 24 patients were *excellent*, of 12 *good*, of eight *fair*, and of six *poor*. Anorexi...

effects (average duration: 13 hours) of the test medication approximated these usual evaluations, but appetite was generally suppressed even in cases of eventual treatment failure. Side effects probably attributable to drug treatment were limited to a complaint of dry mouth, weakness and nervousness in one patient. The present regimen effected an average weight loss of just under . lbs. for periods averaging six weeks. Expressed another way, there was a total loss of 976 lbs. during 2,557 patient days of therapy, or an average loss of 0.43 lbs./day.

When these factors—the fat patient's emotional structure; the physician's own orientation; and the need for enforced motivation by effective diet and medication—are taken into consideration, substantial inroads on obesity are possible. One should not conclude on a discouraging note, but it is well known that the number of patients who are able to maintain their weight for a significant period is frustratingly small. The only benchmark for this program's success will be the degree to which it has permanently changed these patients' eating habits through encouraging the type of emotional maturity needed to ensure long-term favorable results.

REFERENCES

1. MacBryde, C. M.: "Obesity," in Cecil, R. and Loeb, R. F. (eds.) *Textbook of Medicine*, Vol. 1, ed. 10. W. B. Saunders, Philadelphia; 1959, pp. 636-641.
2. Stunkard, A. J.: The "dieting depression"; incidence and clinical characteristics of untoward responses to weight reduction regimens, *Am. J. Med.* 23:77, (Jul.), 1957.
3. Batterman, R. C.: Sustained-action amphetamine-meprobamate combination for the treatment of obesity, *Cur. Ther. Res.* 6:447-453, (Jul.), 1964.
4. Kreinin, S.: Weight control a challenge, *Med. Times* 89:474-479, (May), 1961.
5. Modell, W.: Status and prospect of drugs for over-eating, *JAMA* 173:1131-1136, (Jul. 9), 1960.
6. Rodensky, P. L.: Use of a sustained-release meprobamate-amphetamine preparation in treating obesity, *Cur. Ther. Res.* 3:526-529, (Dec.), 1961.
7. Stuart, D. M.: Obesity and obesity therapy, *Pharmindex* 8:8, (Mar.), 1966.
8. Simeons, A. T.: Chorionic gonadotropin in geriatrics, *J. Am. Geriat. Soc.* 4:36-40, (Jan.), 1956. ◄

Georgetown Medical Center
Georgetown 47122

A hospital for the diagnosis and treatment of psychiatric illness

WABASH VALLEY HOSPITAL

(a not for profit corporation)

2900 North River Road (State Road 43 north)
West Lafayette, Indiana, Phone 317-743-3841

Active Psychiatric Staff	(Phone)	
W. R. VanDenBosch, M.D.	447-6404	Robert K. Jones, Ph.D. Clinical Psychologist
David L. Evans, M.D.	447-9155	
Joe M. Martin, M.D. Edgar C. Stuntz, M.D.	743-1809	Mrs. Margaret Keedy, A.C.S.W. Psychiatric Social Worker
Limited private practice		Elizabeth J. Snyder, R.N. Director of Nursing Service
John H. Wilms, M.D. F. H. Spurlock, M.D. Alfred R. Heasty, M.D.	92-2441	James Jones, B.P.E. Director of Activity Therapy

Donald R. Kinzer, Hospital Administrator

John Sterzer, Business Manager

Admissions are arranged through referral to any active staff psychiatrist.

All general medical and surgical specialties in the community are available through physicians on the open consulting staff.

Routine testing of up to 90% of infants born in Elkhart County over a six-year period demonstrates an incidence in excess of that ordinarily quoted. Early and repeated tests are recommended.

Six Years of Newborn PKU Screening

PAUL H. MARTIN, M.D.
Elkhart*

OVER the past few years there has been increasing attention paid to the inborn errors of metabolism; especially phenylketonuria (PKU). Probably the chief reason for this has been the appearance of relatively simple screening tests. While the results of investigators vary it appears that the incidence is greater than the 1-20,000 to 1-40,000 births previously reported.

A central agency, such as a health department, is a logical place to carry on a screening program. It is easier to have central control than is the case when each hospital and physician's office carries on its own program. The statistical data can also be gathered more easily from one agency than from several. These data will be more meaningful if they are collected under the same programs rather than under several programs using varying procedures.

This paper describes a PKU screening program carried on by a county health department over a six-year period. It will also discuss the dual testing of infants born in one hospital over a three-year period using both the bacterial inhibition method and a ferric compound dipstick method.

Materials and Methods

The Elkhart County Health Unit began a countywide newborn PKU screening program in August, 1961.[1] When an infant is approximately three weeks old, the parents are sent a PKU Kit. The parents test the baby's urine by pressing the dipstick between folds of a wet diaper and return the results to the Health Unit. The test results are recorded on the health department's copy of the infant's birth certificate. In this way a permanent record is always available for further study.

The PKU Kit consists of a letter briefly explaining what phenylketonuria is and the probable results if not detected and treated early; a foil package containing three Phenistix*, and an addressed return postal card. The letter asks the parents to check the infant's urine three times; at about three weeks of age, at six weeks and again at eight weeks. The parents are requested to return the card, whether the test is positive or negative; if positive, the parents should notify the family physician at once.

If the Health Unit does not receive the postal card within a reasonable length of time, a second request is made in which the importance of PKU testing is stressed. If this fails, no further requests are made.

Results

Through a complete six year period, the results on 13,169 infants have been returned. This comprises approximately 90% of all infants born during this period. Four PKU infants have been found by this method:

Infant 1: Male infant born in 1962. The mother did the first diaper test which was negative. She returned the card noting the negative test. Then the remaining Phenistix strips were misplaced and apparently the mother forgot about them. This might have been caused by worry over the infant's severe eczema. The infant was seen by two pediatricians but no PKU tests were done. Finally, when the infant was 14 months old, the Phenistix were found and tests were positive. The appropriate diet was begun; however, this child is severely retarded.

Infants 2-3: Monozygotic male twins were born prematurely in 1963. The first diaper test was negative. Here again the remaining test strips were misplaced. When the infants were five months old the strips were found and positive tests were obtained. Treatment was started shortly thereafter. These twins are but mildly retarded.

Infant 4: Female infant born in 1966. Diaper tests were positive at five weeks of age and dietary treatment instituted one week later. Her physical and mental growth appear to be normal.

In May, 1964, the Health Unit began dual testing, bacterial inhibition (Pheniplate*) and the routine dipstick, on children born at the Goshen General Hospital. This hospital was selected for this program because several PKU infants had been born at this facility and we wanted to know whether or not we could detect any future PKU's at an earlier

* Commissioner of Health, Elkhart.

* Registered trademark of Ames Company, Inc., Elkhart.

* Registered trademark of Ames Company, Inc., Elkhart.

...nd of course start the appropriate ...atment earlier. Through three years ... have had dual testing on 2,565 in...ts. The age at heel stick for the Pi...iplate test has ranged between 16 h...rs and six weeks; the usual age has ...n between 60 and 72 hours. One P... has been found by this method. Be...se of early discharge of the moth... and female infant, the heel stick w... done when the infant was 16 hour...old. The Pheniplate was reporte... as 12 mg/%; subsequent tests ... to 20 mg/%. A definite diagnosis ...was made at two weeks of age and ... appropriate diet instituted. Her progress appears to be normal.

It should be noted that while we consider the Phenistix and Pheniplate tests to be reliable, a final diagnosis is not made nor is treatment started until confirmatory serum phenylalanine levels are determined.

These five cases bring our total of known PKU cases to 25.[2] As has been done with the previous cases, the families are studied to determine whether or not some relatives may have the same condition. The mothers of these children are contacted frequently to watch for any future pregnancies.

Summary

1. The Elkhart County Health Unit has been doing newborn PKU screening since 1961. During that time reports on 13,169 infants have been received. This comprises approximately 90% of the infants born in this period. Four PKU cases have been found.

In one hospital, bacterial inhibition ...sts are done in addition to the routine screening. Over a three-year period, 2,565 children have had dual tests. One infant had a positive Pheniplate test at ... hours of age.

3. The importance of early and repeated PKU tests has been demonstrated.

4. Testing while the infant is still in the hospital assures that nearly 100% of the children will be tested. However, it is generally accepted that one test is not sufficient. Therefore, one must weigh the advantages or disadvantages between one test of 100% of infants, repeated urine tests of fewer children and failure of the parent to carry on the program, as has been demonstrated.

REFERENCES

1. Martin, Paul H.: County Phenylketonuria Screening Program, *JISMA* 57:856, August, 1964.
2. Martin, Paul H., Davis, Louise, Askew, Dorothy: High Incidence of Phenylketonuria in an Isolated Indiana Community. *JISMA* 56:997, August, 1963. ◀

Elkhart County Health Unit
313 N. Second St.
Elkhart 46514

About Our Cover

The "recommendation" on this month's cover, written in 1793, certifies that "Henry Tooley has been studying the practice of Physick and Surgery near eight years under my direction, and that by the assistance of a good genius and close attention, he has made great progress in both studies.

"Since my acquaintance with him he has conducted himself with the strictest moral rectitude, free from the least whisper of scandal and I recommend him as a good member of society to all who may take notice of him."

This month we salute the general practitioner, the mainstay of American medicine. The general practitioner is dedicated and untiring, devoting the major portion of his life to the welfare and well-being of his patients. We realize that physicians are specializing more and more each day, but we hope that the day of computerized medicine remains a daydream and not a reality.—J.F.S. (Harold M. Lambert Studios photograph).

Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension

Enduron: (methyclothiazide) A basic building block for mild hypertensives

Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

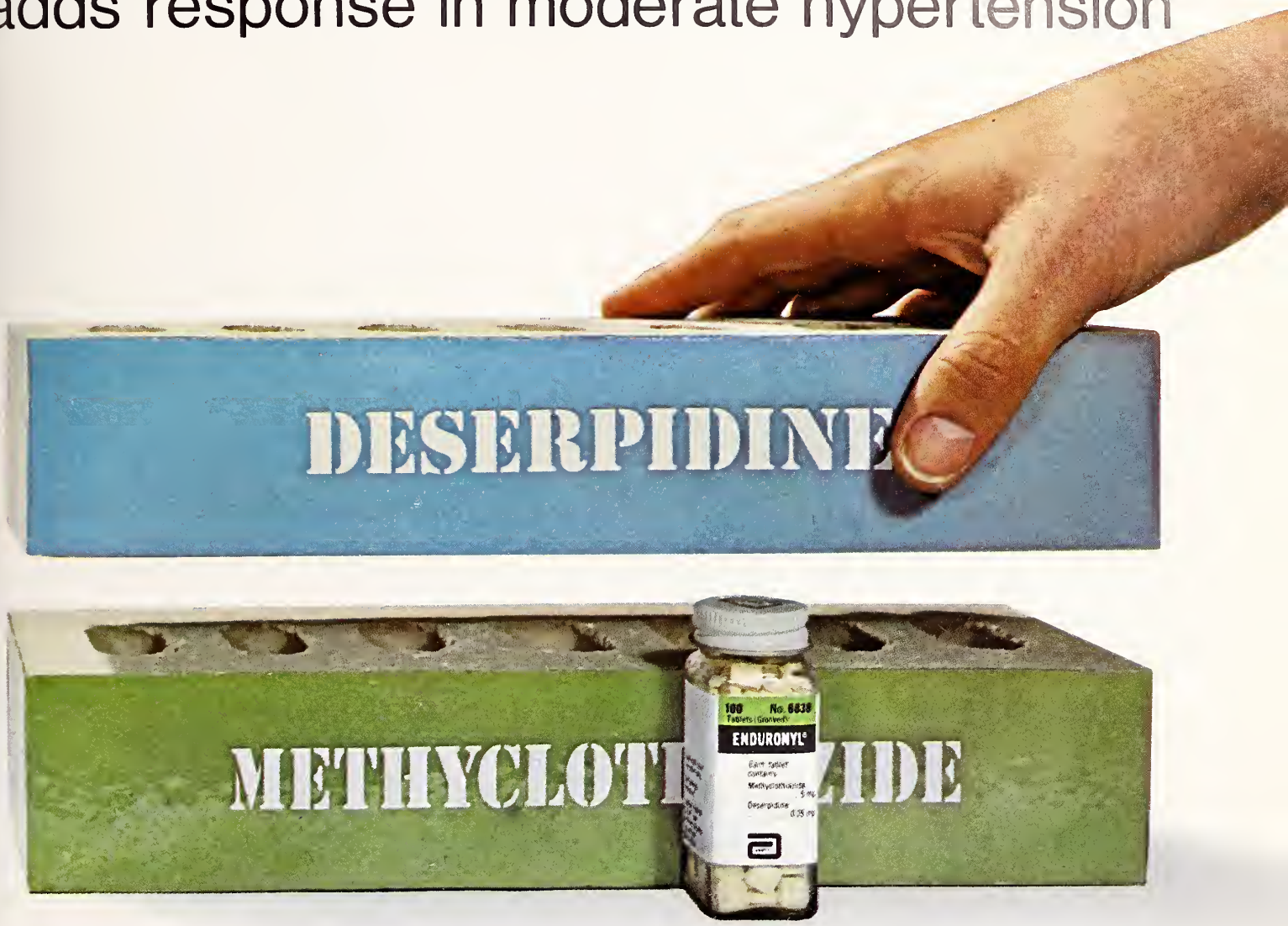
ENDURON®

METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVERE

See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

Once a day, every day

ENDURONYL®

METHYCLOTHIAZIDE 5 mg. with
DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

MILD TO MODERATE TO SEVERE

See Brief Summary on final page of advertisement

801094

Eutron: A unique combination for handling moderate to severe cases

Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE

See Brief Summary on final page of advertisement

801094

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804439R

ABBOTT

TM-TRADEMARK

The great majority of ambulatory diabetic patients of low economic status may be satisfactorily controlled by Dymelor, including some who had previously been on large doses of insulin.

Five Year's Experience with Dymelor

JACK W. HICKMAN, M.D.*
WILLIAM R. KIRTLEY, M.D.**
Indianapolis

ACETOHEXAMIDE (Dymelor†) first became available for clinical trials at Marion County General Hospital in December, 1959. This paper presents the results of these trials on the first 206 patients to whom the drug was given. Data are also presented on 25 of these patients who were maintained continuously on the drug for five years. The basic pharmacology has been reported by others[1-3] and will therefore not be covered.

Methods

Patients were selected for the trials from the outpatient diabetic clinics at Marion County General Hospital. The duration of their diabetes ranged from 1 to 38 years, with an average duration of 6.8 years. There were 151 females in the series and 55 males. The youngest patient was 23 and the oldest was 88 years of age, with an average age for the group of 60.7 years. The age of onset varied from 17 to 79 years of age, with an average age of onset of 53.9 years (Figure 1).

Patients were continued on the same dietary plan that they had been on before Dymelor was started, although the caloric intake was changed in a few patients as the study progressed. The outlined diets ranged from 1,000 calories to 2,100 calories, with the usual diet being one of 1,500 to 1,800 calories.

The patients used in this study represent a very low socio-economic group. This presents a number of problems in the management of the diabetes. Difficulties arise in explaining the diet, insulin and/or oral hypoglycemic dosages. Problems are encountered due to the patient's inability to purchase the proper type of food. It seems unlikely that such a group can be compared with patients reported by the Joslin Clinic[4] in terms of classification of diabetic control. The only reasonable way of assessing the degree of control obtained seems to be to have each patient serve as his own control, current status of drug response being compared with previous response to other regimens. All patients in this series had fasting and postprandial blood sugars obtained at each clinic visit. The values obtained after the patient had been placed on Dymelor were visually compared with the blood sugars reported prior to the study. We have, accordingly, grouped the 206 patients into "same," "better," and "worse" groups by this method.

Dymelor was generally given in divided doses throughout the day, ranging from 250 mg. per day to 3,000 mg. per day. Sixty percent of all patients received between 500 mg. and 1,500 mg. daily.

Liver function was evaluated by obtaining thymol turbidity, alkaline phosphatase, serum glutamic oxaloacetic transaminase (SGOT), and total serum cholesterol tests before Dymelor was started and at intervals during the study. These studies, with the exception of serum cholesterol, were carried out on 175 of the 206 patients. The cholesterol determinations were obtained on 103 patients.

Results

Of the total 206 patients who started the study, 121 (59%) were judged to be in better diabetic control than on their previous program; 57 patients (28%) were judged to have roughly the same degree of control; 24 (12%) were judged to have worse control; and in four patients (2%) it was impossible to evaluate because of incomplete data.

Of the 41 patients who had been managed by dietary control alone, 33 (80%) had better control after Dymelor was instituted; seven patients (17%) had roughly the same degree of control; and one patient (3%) was in poorer control.

There were 112 patients who had previously been treated with one or more oral hypoglycemic agents before being changed to Dymelor. Of this group, 64 patients (57%) showed better control on Dymelor; 36 patients (32%) had the same

* Director of Medical Education, Marion County General Hospital; Associate Professor of Medicine, Indiana University School of Medicine.

** Director, Medical Research Division, Eli Lilly and Company; Assistant Professor of Medicine, Indiana University School of Medicine.

† Eli Lilly & Co., Indianapolis.

degree of control; and 12 patients (11%) had poorer control.

There were 109 patients in the series who had been on insulin at some stage in the course of their disease. Of these patients, 59 (54%) showed better control of their diabetes when placed on Dymelor; 33 patients (30%) maintained the same degree of control; and 17 (16%) had poorer control (Figure II).

These 109 patients were further divided into three groups: those whose insulin dose was never over 20 units per day; those who received 21-40 units per day; and those who received over 40 units of insulin per day. It should be emphasized that this insulin dose is the maximum amount taken. It does not necessarily mean that the patient was taking either insulin or the dose listed immediately prior to the institution of Dymelor therapy.

In the first group, those patients who had received 1-20 units of insulin per day, there were 21 patients. Of these, 11 patients (52%) had better control on Dymelor; six patients (29%) had the same degree of control; and four (19%) showed poorer control of their disease.

There were 53 patients who had required 21-40 units of insulin per day at some time during their disease. Of these patients, 36 (68%) had better control on Dymelor; 10 (19%) had roughly the same degree of control; and seven patients (14%) manifested poorer control.

Of the 35 patients who had taken over 40 units of insulin per day in the past, 12 patients (33%) showed better control on Dymelor; 17 (50%) had the same degree of control; and six (17%) were in worse control.

Combined therapy of Dymelor and DBI* was used in 27 patients.[5] These were individuals in whom control of diabetes on Dymelor alone left much to be desired. Of these patients, 14 (52%) had better control than with a single agent; 10 (37%) had no change in degree of control; and three (11%) had poorer control. All three of these patients were returned to their previous management of NPH insulin.

There were only two patients in the series in whom it was decided to supplement the patient's daily insulin dose with Dymelor therapy. These patients were given 500 mg. of Dymelor per day in addition to their NPH insulin. In neither case did the Dymelor appear to have any effect at all on the diabetic control.

Liver function tests prior to and after six to 60 months after the institution of Dymelor therapy yielded the following results:

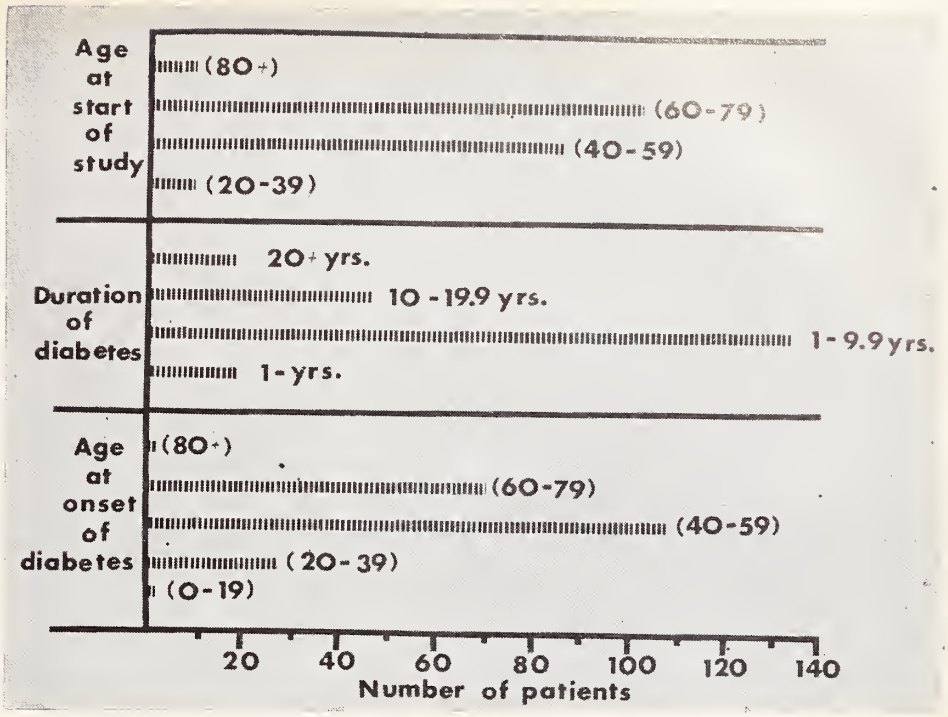


FIGURE I

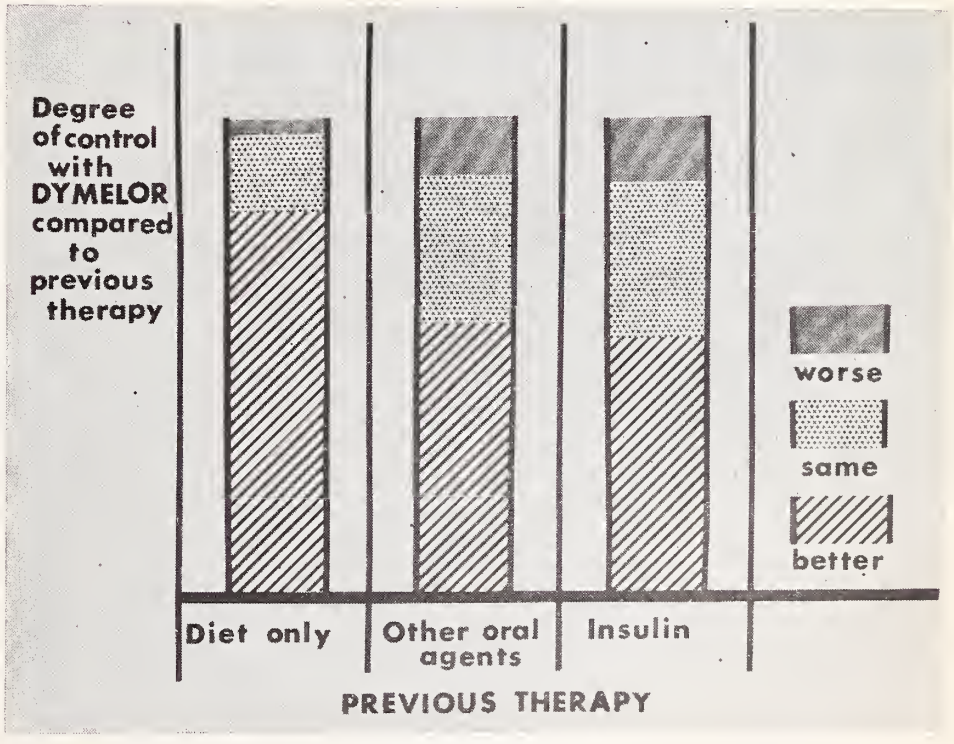


FIGURE II

* USV Pharmaceutical Corp., New York, N.Y.

	Pre-Dymelor Averages	Post-Dymelor Averages
Thymol Turbidity*	2.12 units	1.86 units
Alkaline Phosphatase (K-A)*	10.8 units/100 ml.	11.4 units/100 ml.
SGOT*	26.3 units/ml.	23.5 units/ml.
Serum Cholesterol**	230 mg./100 ml.	219 mg./100 ml.

* 175 patients
** 103 patients

Of the 206 patients studied, 17 patients (8%) could be classed as secondary failures. Of these, there are indications that two of the patients were those who probably should not have been candidates for Dymelor to begin with, because of previously large insulin requirements. A third patient developed his lack of response of Dymelor coincident with the institution of chlorthiazide therapy. Removing these three patients from consideration gives a 7% secondary failure rate for the entire series.

There were 12 patients (6%) in whom the drug was discontinued because of troublesome side effects. Actually, in seven of these cases the "side effects" were considered to be hypoglycemic episodes. In the remaining five cases, two patients experienced troublesome pruritus, one had "dizzy spells," one patient stated that he "couldn't tolerate" the medicine, and in one case it was stopped because of a rising alkaline phosphatase determination. Six other patients experienced milder side effects, such as pruritus, mild hypoglycemic episodes, or headaches, but these symptoms cleared after the dosage was lowered and it was not necessary to discontinue the medication. No patients developed jaundice[6] or bone marrow depression during the five years of the study.

Considering the 25 patients who have been maintained on the drug continuously for five years, 14 patients (56%) had better control than prior to the Dymelor therapy and 10 patients (40%) had roughly the same degree of control. There was one patient who was considered to be in poorer control than at the beginning of the study, yet she was continued on Dymelor for five years. Why this patient, who has been considered as a secondary failure, was not switched back to her previous therapy, which was 15 units of NPH insulin, cannot be explained. The liver function studies on 24 of these patients (baseline studies were not obtained in one case) gave the following results:

	Pre-Dymelor Averages	Post-Dymelor Averages
Thymol Turbidity	2.0 units	1.6 units
Alkaline Phosphatase (K-A)	9.7 units/100 ml.	10.1 units/100 ml.
SGOT	26 units/ml.	21 units/ml.
Serum Cholesterol	220 mg./100 ml.	222 mg./100 ml.

The poorest group of responders were those patients who were taking over 2,000 mg. of Dymelor per day. There were 21 such patients. Of this group, only seven (33%) were judged to have better control; nine patients (43%) had the same degree of control; and five patients (24%) had poorer control.

Discussion

This study has shown that Dymelor provides an acceptable form of oral hypoglycemic therapy for the ambulatory patient. Diabetic control was not maintained at optimal levels in many of the patients, to be sure, but those physicians who have had years of experience in such clinic operations will realize the limitations placed on diabetic control. If the 206 patients in this series were tabulated as to degree of control used by the Joslin Clinic, the great majority would be in "fair" or "poor." Since the average duration of diabetes was 6.8 years in this series, the authors were personally acquainted with the great majority of the patients and had followed them for some years before Dymelor was started. We had the advantage of knowing the seriousness of their disease, their particular problems relating to control, and a realistic idea of what goals we might strive for in pursuit of control. It is felt that the only valid comparison to make within such a clinic group is a comparison of the degree of control (or lack of it) during certain periods of therapy with previous levels of control. Obviously, this method is open to error and is thrown off by dietary changes, positive or negative placebo effect, weight changes, etc.

The best controlled group were those patients who had been managed by diet alone and the poorest results were in those patients taking over 2,000 mg. of Dymelor per day. This latter fact confirms our clinical impression that once one starts "chasing" the patient's disease with ever larger doses of an oral agent, the likelihood of success decreases.

Dymelor certainly appears to be as effective as other oral agents used in our clinic; in fact, the control obtained from it was generally superior to that of the other oral hypoglycemic agents.

Although there was a roughly inverse correlation between maximum insulin dosage and chance of success with Dymelor, the fact that 33% of patients who had taken over 40 units of insulin per day did show better control on Dymelor does indicate that a daily insulin dose *per se* is not a contraindication to the use of Dymelor. In fact, one of the patients judged to have better control with

Dymelor had once required 90 units of NPH insulin per day and one patient judged to have equally good control had taken 125 units of Lente insulin per day in the past.

Certain selected patients obtained reasonably good control of their disease when placed on a combination of Dymelor and DBI therapy. This combined therapy can be of value to some patients when a single agent does not seem to be providing desired control. Side effects were no more frequent in this group than in the group who received Dymelor alone.

This study confirms the previously reported safety of Dymelor as an oral hypoglycemic agent. There was no derangement of liver function tests, even in the patients who had taken the drug for five years consecutively. The most frequent "side effect" of the drug was hypoglycemia and this disappeared in a number of instances when the dosage was lowered.

Summary

Dymelor is a safe, effective oral hypoglycemic agent. It was quite suitable for use in an ambulatory patient clinic practice and afforded a degree of control of these patients that was generally more desirable than previous methods of management had achieved. The drug was well tolerated for long-term therapy for these patients and gave no evidence of serious side effects.

BIBLIOGRAPHY

1. Maha, G. E., Kirtley, W. R., Root, M. A., Anderson, R. C.: Acetohexamide—Preliminary Report on a New Oral Hypoglycemic Agent, *Diabetes* 11:83, 1962.
2. Radding, R. S., Kern, L. R., Owens, J. C.: Comparative Pharmacology of the Sulfonylureas, *Metabolism* 11:411, 1962.
3. Galloway, J. A., McMahon, R. E., Culp, H. W., Marshall, F. J., Young, E. C.: Metabolism, Blood Levels and Rate of Excretion of Acetohexamide in Human Subjects, *Diabetes* 16:118, 1967.
4. Cervantes-Amezeua, A., Naldjian, S., Camerini-Davalos, R., Marble, A.: Long-Term Use of Chlorpropamide in Diabetes, *JAMA* 193:759, 1965.
5. Goodman, J. I.: Role of Phenformin (DBI) as an Adjuvant in Oral Antidiabetic Therapy, *Metabolism* 14:1153, 1965.
6. Goldstein, M. J., Rothenberg, A. J.: Jaundice in a Patient Receiving Acetohexamide, *New Eng. J. Med.* 275:97, 1966. ◄

Vacation trip....

Motion sickness?

This time it'll be different. Emetrol taken before the trip begins will usually prevent nausea and vomiting. Emetrol is effective and safe...most helpful where safety is most important. It acts locally—not systemically.

ROER

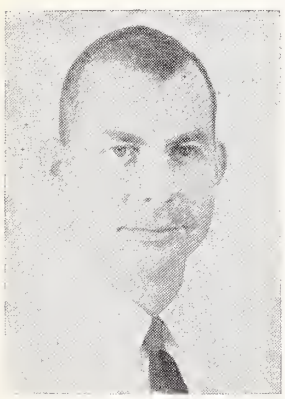
WILLIAM H. RORER, INC.
Fort Washington, Pa.

Emetrol®
phosphorated carbohydrate solution
emesis control

Treatment of Epilepsy

JOSEPH B. GREEN, M.D.
Indianapolis*

A discussion of the treatment of epilepsy might well begin with the patient in the throes of a grand mal seizure. He should be protected against injury but not tightly restrained. Objects such as tongue blades should not be forced into his mouth. Following the attack, the patient should be turned on his side to maintain an adequate airway and prevent aspiration. The injection of a drug is unnecessary after a single brief attack. In the event a second convulsion follows shortly after the first, a barbiturate such as phenobarbital should be injected intramuscularly, 100-200 mg for an adult. If there are serial convulsions it is best to rely on intravenous phenobarbital, 130 mg, at 30-40 minute intervals. Should the patient fail to respond to two or three such injections, intravenous pentothal is indicated, with provision for artificial respiration and intubation.



Valium has recently been found effective in terminating status epilepticus, and may become the drug of choice in the treatment of this disorder. It is given slowly intravenously in a dosage of 5 to 10 mg for adults — 2 to 5 mg for children.

* Associate Professor of Neurology; Director, Epilepsy Clinics, I.U. School of Medicine, Indianapolis 46202.

A convulsion may damage nerve cells. Because one attack creates a probability of a second, most patients who have had a convulsive seizure should be treated with anticonvulsant medication, irrespective of what may have triggered the convulsion. Febrile seizures should be prevented by regular daily doses of phenobarbital or Dilantin. A normal or negative electroencephalogram should not deter treatment.

It is important to initiate treatment promptly, using a single drug in a sufficiently large dosage. Prompt control of the seizures instills confidence in the physician's management and helps to motivate compliance with his recommendations. Toxic doses at the outset should be avoided, not only because of the debilitating effects but because of the incorrect implication that the control of seizures must be contingent upon "doping or drugging" the patient. Anticonvulsant medication may, as a rule, be taken two or three times a day. It is the rare patient, indeed, who must take his medicine on an exact schedule. For most, a morning and evening dose will suffice. Because a number of drugs may irritate the gastric mucosa, it is usually desirable that medication be taken after meals, or if at bedtime, with some milk.

The majority of patients whose seizures can be controlled will respond to phenobarbital or Dilantin. Phenobarbital is perhaps the single drug which may be used for all types of seizures, although it rarely suffices for the control of the varieties of petit mal attacks. Related barbiturates offer little advantage over phenobarbital and are more expensive, an important consideration in long-term treatment. The dosage of phenobarbital required ranges from 1-5 mg/kg/day, but some patients may tolerate 400-600 mg per day, with little evidence of sedation. In young children the drug occasionally produces hyperactivity and irritability. The appearance of a rash requires discontinuation of therapy. The sudden withdrawal of phenobarbital may precipitate seizures and status epilepticus.

Dilantin equals or surpasses the suppressant effect of phenobarbital on generalized convulsive seizures, and is less sedative. The dosage range is 3-8 mg/kg/day, subject to wide variations. Children two or three years of age can tolerate 100 mg daily quite well; those five to ten years of age can take 200 mg; and older children and adults tolerate 300-400 mg per day. The quantity of Dilantin that can be used is limited by such toxic effects as ataxia, incoordination, diplopia and tremor. Some patients may require 500-600 mg per day, but doses of this magnitude are rarely desirable because of the frequency of toxicity and disappointing results. A number of weeks of Dilantin administration may be necessary to affect seizure frequency; a reduction in dosage may result in seizures after a delay of a few days. The sudden discontinuation of Dilantin therapy, intentional or otherwise, is an important cause of status epilepticus.

Gingival hypertrophy, acne and hirsutism are annoying complications of Dilantin therapy, but if the drug has proved effective in controlling seizures, it should not be decreased in an attempt to minimize the undesirable effect on the gums. A gingivectomy is the preferred management. A morbilliform rash, fever and glandular enlargement, make it necessary to discontinue the drug. Serious hematologic complications are unusual but a macrocytic

anemia, responsive to folic acid, is occasionally observed.

Zarontin is at this time the drug of choice in the treatment of petit mal seizures. Serious toxic effects have been rare, although a few cases of blood dyscrasia have been reported. The usual dosage is a 250 mg capsule 2-4 times daily. Side effects include anorexia, nausea, vomiting, drowsiness, behavioral changes and rash. Zarontin is most effective against simple staring spells, and least effective against drop attacks and myoclonic seizures. It has little or no effect on grand mal or psychomotor seizures. Psychomotor seizures are differentiated from petit mal by the presence of an aura, a longer duration, and a postictal state.

Combinations of anticonvulsants may be helpful in resistant cases or in mixed seizure disorders. The drugs are best given in separate preparations for flexibility in dosage and so that side effects may be properly attributed. Dilantin and phenobarbital are commonly used together in grand mal and psychomotor epilepsy. A child with petit mal and grand mal epilepsy may need both Zarontin and phenobarbital, the latter to prevent convulsions. The addition of Dilantin might more effectively control the major attacks, but might increase the frequency of the petit mal. Occasionally, controlling petit mal seizures may precipitate grand mal attacks. In some cases of mixed seizure disorders, large doses of phenobarbital are the only effective treatment. Space does not permit a discussion of several useful drugs, such as Mysoline, in the treatment of grand mal and psychomotor seizures, and Tridione, Paradione and Celontin in the treatment of petit mal.

Anticonvulsant therapy should be continued until after a seizure-free period of two years, and should not be discontinued during puberty or in an individual who might be exposed to serious risks. The patient and his family should be seen frequently in the early days of treatment, to check for toxicity, to establish an optimum drug dosage, and to help in the adjustment to the illness. If the side effects of medication seriously impair physical and mental functioning, it may be necessary to accept less than complete seizure control.

An "epileptic" must surmount psychological and social barriers, although often handicapped in his learning and adaptive abilities. Parental overprotection or rejection of the epileptic child often leads to the formation of undesirable character traits. Many patients are emotionally and socially immature, deficient in self-care and work skills. It is the responsibility of the physician to see that his patient obtains needed educational and vocational counseling, and to refer the family to a psychiatric resource, where appropriate. ◄

From *The Journal* 50 Years Ago

. . . When we contemplate that a number of patients visit our offices each month who have tonsil crypts filled with disease-producing bacteria and pus, diseased teeth, blocked up sinuses, infected fallopian tubes, and prostates, which sites serve as culture tubes containing culture media for the propagation of disease producing organisms, how important it is that we should call these serious facts to their attention and to the attention of physicians, that they may cooperate with us in the abatement of these sources of danger. Let us urge the need for prompt and diligent search for these primary foci and their immediate eradication.

We have been prone to permit patients to call these ocular lesions a "cold" in the eyes, "catarrh in the eyes," or "pink eye," for most sore eyes are red and patients have an idea that pink eye is anything that makes an eye red and apt to be a mild disease. These fallacious notions are harmful, because patients think this "cold in the eye" will subside as any other slight cold, especially if he resorts to the popular domestic remedies, such as "onion" or "potato poultices."

We should be diligent in teaching the patients and the public that these eye diseases . . . may be an active and virulent infection in the eye which had its breeding place in the throat, nose, tonsils, abdominal cavity or pelvis, and that it is not only needful promptly to relieve the eye disease in hand, but to search for and remove the primary cause, and that this procedure may not only mean the saving of his sight, but by removing or destroying the incubator, we may lessen the probability of a return of the eye disease, may also reduce his liability to meningitis, myositis, nephritis, ulcer of the stomach, thyroidism, appendicitis, and rheumatic fever with its attendant cardiac complications. . . . S. A. Shoemaker, M.D., Bluffton, "Ocular Diseases due to Foci of Infection Adjacent to or Remote from the Eye," *JISMA*, August, 1918.

What Constitutes Legal Death

JOHN C. GREEN, B.S.
Greenwood*

"Not long ago a wealthy southern shipowner, fatally injured in an accident, was rushed to the hospital. Though he was presumed to be dead on arrival, a team of doctors put forth heroic efforts to get his heart beating again. They succeeded, and kept it going weakly and erratically for some 40 minutes. When further efforts failed, they finally pronounced him dead. Meanwhile, during the same critical 40 minutes, a baby girl was born to the shipowner's only daughter. The daughter had married against her father's wishes. As a result, he had disowned her, though setting aside $100,000.00 for any grandchild who might be born before his death."[1]

The above situation presents an important legal question. The will of a decedent does not become effective until the death of the decedent. When then does the will of this man take effect? Does it take effect when he is pronounced dead on arrival at the hospital or does it take effect after the efforts of the doctors to revive him fail? This is a critical question due to the time of birth of his granddaughter.

The question of the time of death leads to the question of what constitutes death. When can one say this man is dead?

The legal profession is without a concrete, workable definition of death, and as strange as it may seem, the medical profession is also in need of a definition of death. As stated by one physician:

"The world has the right to look to our profession for a set of internationally accepted criteria for the definition of death. Death has always been the enemy we have been trained to fight. In one sense, we never conquer death; we only postpone it. But it does seem odd that *after many millenia of coming to grips with it, we have never even defined the enemy.*"[2] **(Emphasis the author's).**

It is relatively simple to say that a person is either alive or dead. Death is the opposite of life. But the question that must be resolved is when and how does one differentiate between prolongation of life and prolongation of death.[3]

"Malignant Spirits"

In early times, death was an easy term to define. It was not a difficult term in the savage world because there was an easy and simple reason why a person died. The savage world felt that illness resulted from the "entry into the body of strange and malignant spirits and their combat with the inner friendly spirit."[4] Signs and outward symptoms of the above struggle were evident from observation of the individual. Internal illness resulted from the resident spirit's resistance against being driven or enticed from its earthly abode. Death ensued when the spirit left the body permanently. In the last breath one could observe the spirit leaving his earthly abode ". . . through the mouth or nose, or running away with the ebbing blood."[5]

When the malicious spirit had succeeded in forcing the friendly spirit to leave, the departing spirit began a journey. The course and destination of the journey depended upon the religious culture of a given civilization. Most cultures provided the spirit with the essentials necessary for a good earthly journey in the burial tomb. "The spirits of the dead were personified and had subjective needs—food, drink, and shelter."[6]

The idea of immortality of the soul, as understood today, was not known among early civilizations. The Egyptians viewed death as a continuation of life. With their relatively advanced civilization they erected tombs in which they placed the necessary artifacts for travel, nourishment, weapons of defense, etc.[6(a)]

"Popular" Tests for Death

Later, as civilization advanced, physicians would look to the heart and respiration to determine death. It was reported, for example, in England in 1742, there was a man who in all outward appearances died whenever he pleased.

"A physician reported his heart ceased to beat, there was no perceptive respiration, and his whole frame became cold and rigid as death itself . . . . He performed the experiment in the presence of three medical men; one of whom kept his hand on his heart; another held his wrist; and the third placed a looking glass before his lips."[7]

Other "popular" tests for death were employed. One such test consisted of tying a ligature around a finger. If the finger became congested, circulation was present and the individual was not dead. Another test involved the opening of an artery to see if blood would be pumped out. Sometimes an injection of some substance such as fluorescein would be used which would be carried by circulating blood and would be-

* Senior at Indiana University Indianapolis Law School; Research assistant for the Honorable Judge James C. Cooper, Judge of the Indiana Appellate Court.

come visible in the conjunctiva.[8]

There existed various tests to determine if respiration had stopped. For example, the physician would place a glass of water filled to the brim on the top of a person's chest. If there were any movements of respiration, the water would spill out of the glass. Physicians would also place a mirror over the lips of the individual to see if it became dimmed.[9]

Before the new concept and procedures of transplantation of organs, death was generally defined as "the arrest of vital functions."

> **"Fifty years ago this meant the arrest of the circulation, respiration, and motor and sensory functions of the central and peripheral nervous system. But even then the medicolegal specialists would be obliged to admit that although this definition was convenient for teaching or for the public, it was not in line with current knowledge of death. Even in 1920, there was a discrepancy between the official idea of death and what the doctor knew. In the eyes of officialdom there is a moment at which death takes place, and it is customary to say and to write that Mr. X died on such a day at such a time, sometimes recording the actual minute of death."**[10]

When considering the definition of death the term must be separated into two areas—the concept of death, and the procedure in stating and pronouncing death. Clergymen, philosophers, and others are interested in the concept of death. However, to the medical doctor and lawyer, the procedure of death is quite critical.

Clinical Death vs. Medical Death

Basically there are two definitions of death. One definition is the definition of clinical death, and the other is the definition of medical death.

Houts in *Courtroom Medicine,* defines clinical death as:

> **"Clinical death occurs when there are no observable or perceptible vital signs of life. These include heartbeat and respiration, and in some rare cases where the patient is in the operating or examining room, also measurable brain wave activity.**
>
> **"There is an interval of time after clinical death, usually said to be between three to five minutes or three to seven minutes, during which the failure of respiration and/or heartbeat can sometimes be reversed and restored through the use of artificial respiration, or heart massage and artificial stimulation. This is the period during which effective resuscitation can be accomplished, before irreversible brain damage takes place."**[11]

The concept of clinical death is involved and extremely complex. For in the definition of clinical death lies a period of "dying" or agony. This period of agony makes it clear ". . . to the medical profession that death is a process and not a moment in time as the law believes."[12] Dr. Muller further stated at page 141 of *The World Medical Journal:*

> **"Etymologically, the word 'agony' means 'struggle' and a struggle implies the idea of victory and defeat, either the victory of an illness over the human body or of the latter over a pathological process. However, agony is not that at all. It is a period during which death is already certain and during which the body is fighting to stave off the inevitable. Thus, in practice, the idea of agony implies irreversibility."**[13]

Houts elaborates more on "dying", or agony, by pointing out that each tissue of the body dies its own particular death with such process being instantaneous or drawn out, depending upon the type of tissue.

Houts defines medical death as follows:

> **"Medical death occurs when this interval of possible resuscitation following clinical death has passed. Medical death is final and irreversible."**[14]

To carry the concept of medical death one step further, medical death must be used in all other situations where a heart-lung resuscitator and electroencephalograph are not at hand. In a small town where a physician does not have use of the above equipment, he must base his definition on the action of the heart, respiration and other physical signs. If the heart stops beating for a period of between three to eight minutes, the brain will be irrevocably damaged. Cessation of breathing cannot alone be used to determine death because the heart can beat many minutes after breathing has stopped. A common illustration is a person who is revived after having been pulled from a lake. Respiration had ceased but the heart remained functioning.

> **"Death and dying not only cause changes in form and structure, but certain functions and reactions work toward the fatal end. These changes can be analyzed histochemically . . . and electromicroscopically.**
>
> **"The presence of life, which is function, is closely linked to metabolism; and the cessation of metabolism means death. It should, therefore, be understood that the condition referred to as 'dead' belongs in the realm of 'function' rather**

than in the realm of 'form.'

"As long as the metabolism is balanced in favor of assimilation, with increase in performance, the anabolic phase prevails. When dissimilation with decrease in performance overbalances the catabolic phase has set in. The arresting point between these two metabolic extremes constitutes, theoretically speaking, the true moment of death."[15]

If Houts is correct in his assumption that "the presence of life" is function. then possibly function should be the critical test of when clinical death becomes medical death and ultimately "legal death." Assume that to determine function of an individual we must think of what ultimately places man highest in the animal kingdom—that in essence being his brain and thus his ability to reason. If man could not reason then he would be reduced to a lower form of animal. If the function of man ends when his brain "dies", then man is reduced to a vegetable. A vegetable in that the processes of the body may continue either by the natural organ functions or by external aids such as a heart resuscitator. Dr. Hannibal Hamlin, Boston's neurosurgeon, stated that:

"Although the heart has been enthroned through the ages as the sacred chalice of life's blood, the human spirit is the product of man's brain, not his heart."[16]

When operating in the area of clinical death where medical machines are used to perform vital functions such as resuscitation and circulation, the only way to say when an individual is legally dead is by an electroencephalogram (EEG) showing an absence of waves for a period of time.[17]

Open or closed heart massage often reanimates the heart that has stopped or ceased to perform adequately. The heart-lung resuscitator combines the administration of oxygen and a plunger action to the chest to restart the heart. Hence, the vital functions of man can be prolonged by artificial means. However, the mechanical aids after "death" of the brain has occurred, says Dr. Hamlin, can only "maintain the look of life in the face of death."[18]

When to Pull the Plug Out

The question of when does the "function" of man cease when placed on mechanical aids, was asked by Harvard's Dr. Robert S. Schwab, "When do you pull the plug out and make this expensive equipment available to someone who might live?"[19]

A possible answer to the question of when does a physician "pull the plug" may be answered by criteria set forth by the American Electroencephalograph Society for determining brain death. The criteria are as follows:

1. **"No hypothermia or anesthetic drug levels.**
2. **"No reflexes, spontaneous breathing, or muscle activity.**
3. **"A flat electroencephalogram at gains of 50 microvolts per 5 mm. through 15 mm. over a 20 minute period of continuous recording.**
4. **"No clinical or EEG response to noise or pinch.**
5. **"A repeat of all these conditions 24 to 72 hours later."**[20]

One can easily see objections to these criteria from the pathologist, mortician, and most important, from those engaged in organ transplantation.

The Society also suggests that the responsibility of "when to pull the plug" should be shared with the family, medical colleagues, attending nurses, and possibly the medical examiner or coroner.[21]

An important point to bear in mind is that the attending physician after consultation with the above mentioned parties, should have complete discretion as to the precise time of removing the medical aids. Furthermore, another major factor that a physician must consider is as Dr. Zukoski of V.A. Hospital in Nashville stated in *Time Magazine:*

"When the physician decides to support the patient with mechanical aids he runs the risk of letting the machine become his master."[22]

As T. R. Van Dellen, M.D., stated in *The Illinois Medical Journal*:

"There is merit in letting the oldster or person with a chronic or fatal disease die with dignity. Never start any process that might be difficult to stop."[23]

The crucial point of the criteria presented by the American Electroencephalograph Society is that there be no clinical or EEG response of the brain. In other words, the brain is dead. The difference between a living brain and a dead brain can be easily seen from electroencephalograms (EEG). In Figure 1, the EEG is from a living brain with some seizure activity. (This is not the normal EEG but it is sufficient for purposes of demonstration.) The wavy lines represent both impulses from different points of the brain as well as electrical impulses from the heart. Cerebral death occurs when the gain (sensitivity) of the machine is turned up as high as it will go and the only reading shown is from residual electrical impulses from the myocardium.

In Figure 2, the EEG from a dead brain, the wavy line at the bottom of the reading is only from the heart and not from the brain. This is only a residual impulse from the heart much like an echo resulting from a loud shout. It does not represent blood circulation through the heart but only the echo of residual impulses.

EEG readings are taken by placing electrodes at different locations around the head. The sensitivity in Figure 1 is as high as can be registered on the machine. In Figure 2, the sensitivity is also turned up to maximum output. In Figure 1 the brain and heart impulses are readily apparent; whereas in Figure 2 only the residual heart impulses are picked up. In Figure 1 the brain is alive and functioning; whereas in Figure 2 the brain is dead and functionless.

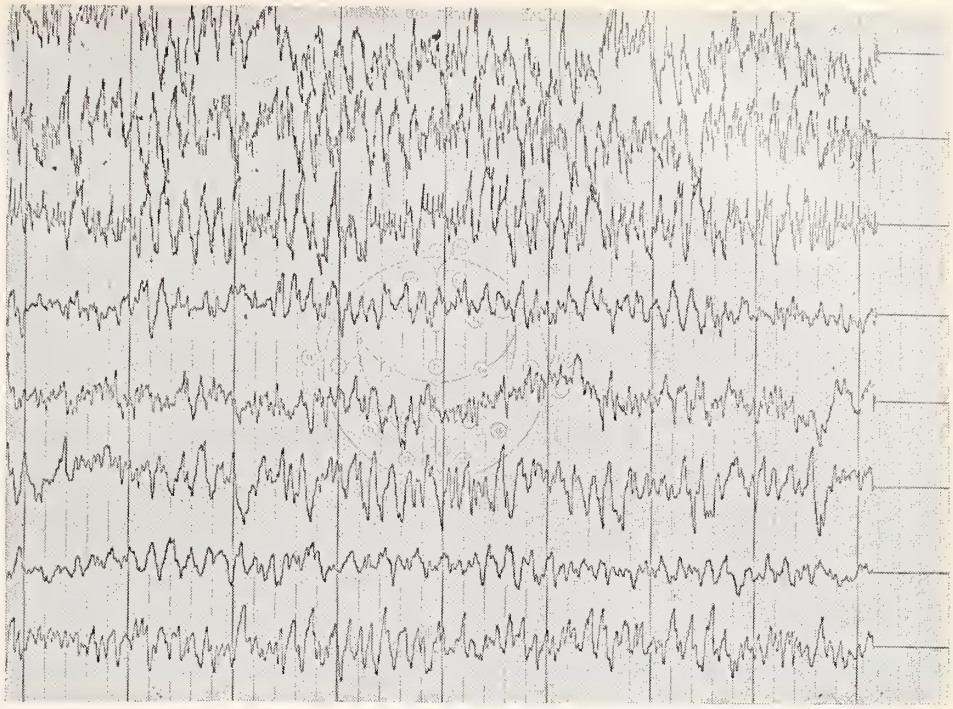


FIGURE I

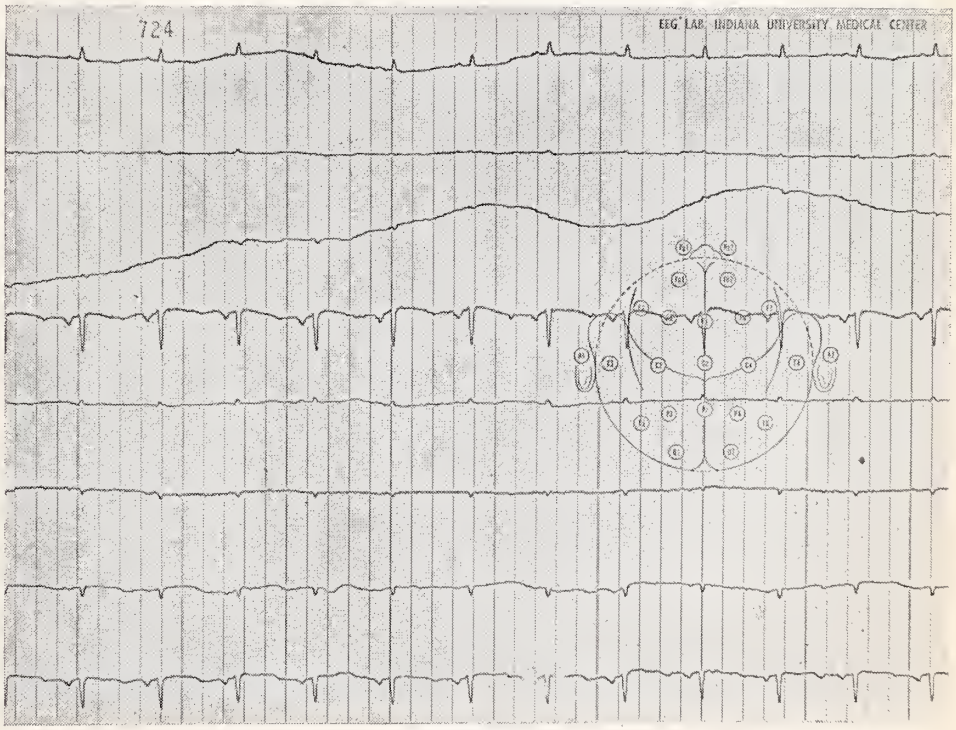


FIGURE II

Legal Death

The legal profession out of necessity must base its definition of death upon the definition adhered to by the medical profession. In Smith v Smith, (1958) 299 Ark 579, 317 S.W. 2nd 255, 279, the court used a dictionary for its meaning of death:

> **" 'Death' is the cessation of life; the ceasing to exist; *defined by physicians* as the total stoppage of the circulation of the blood and a cessation of the animal and vital functions thereon, such as respiration, pulsation, etc." (Emphasis the author's).**

In some cases the courts have even avoided defining death. The New York court in Evans v People, 1 Crow Cr. Report 434, defined death as:

> **" 'Death' is the opposite of life. It is the termination of life."**

Furthermore, in Finch v Edwards (1947), 239 Mo App 788, 198 N.W. 2nd 665, the court stated that ". . . death when used with respect to a person is commonly and ordinarily understood to mean departure from life."

It takes little imagination to envision a judge attempting to use the above definitions when the exact time of death is critical to a case. With today's advanced medical technology and the expectation of even greater advancement in the future, this is a real and pressing problem. Legal death must therefore be revised and refined for modern day use in the courtroom.

In light of the above discussion of the medical definitions, there would appear to be several necessary points for consideration in a legal definition of death. Legal death is a question of fact. Much is dependent on circumstances and the situation involved. Hence, any legal definition would have to be flexible. The circumstances of death would have to be weighed by the trier of facts. In normal circumstances where the time of death was not critical, legal death would then be the above definition of medical death given by Houts. In that if the individual is in such a position that no mechanical aids are in

operation, the physician must determine, at his discretion, death as occurring when respiration ceases and approximately eight minutes after the heart stops. For at this time, the physician knows that irreversible brain damage has occurred and the patient is medically dead. Hence, this would be designated as the "legal time of death."

In certain circumstances where the precise time of death may be critical from a legal standpoint, the time of death should be based on a flat EEG over a period of at least 24 hours. Therefore, in a circumstance where time of death is critical, as for example in determining contingent beneficiaries, and mechanical aids are in operation on the individual, an EEG is the only means of determining medical death.

In both situations the time of death must be left up to the discretion of the attending physician. This is absolutely necessary. The legal profession has neither the knowledge nor the technology to sit as an expert and determine this oftentimes critical decision. However, since the definition of death is critical to the legal profession, it is necessary that both the legal profession and the medical profession agree on the standard, procedures and definition involved in "death." With the current and future advances of technology, an agreement upon a workable definition of death must be formulated now!

REFERENCES

1. Rosenfeld: Control of Life: The New Man, *Life Magazine*, October 1, 1965, Vol. 59, p. 96.
2. Editorial, *Journal of the Medical Society of New Jersey*, Vol. 64, No. 3, March, 1967, p. 100.
3. Ibid.
4. Jackson: *The Law of Cadavers*, Second Edition, New York, 1950, Prentice Hall Inc., p .3.
5. Ibid.
6. Ibid.

6.(a) Breasted: *Development of Religion and Thought in Ancient Egypt*. p. 61: Brendann: *Death Customs*, p. 180.

7. Timbs: *Mysteries of Life, Death and Futurity*, London, Kent & Co., 1861, p. 134.
8. Kerr: *Forensic Medicine*, A & C Black Co., 6th Edition, 1957, pp. 54-60.
9. Ibid.
10. Muller: Legal Medicine and the Delimitation of Death, *World Medical Journal*, Sept.-Oct., 1967, p. 140.
11. Houts: *Courtroom Medicine*, Death, Vol. 3, 1967, §1.02.
12. Muller: *Legal Medicine and the Delimitation of Death*, supra.
13. Ibid.
14. Houts, *Courtroom Medicine*, supra.
15. Ibid.
16. *Time Magazine*, Medicine, May 27, 1966, p. 78.
17. Editorial, The Moment of Death, *World Medical Journal*, Sept.-Oct., 1967, p. 133.
18. *Time Magazine*, Medicine, supra.
19. *Time Magazine*, Medicine, supra.
20. *Medical Tribune*, Criteria For Death of Brain Aimed to Reduce Lawsuits, 1967.
21. Van Dellen: Alive or Dead, *Illinois Medical Journal*, Vol. 132, No. 4, Oct., 1967, p. 579.
22. *Time Magazine*, supra.
23. Van Dellen, *Alive or Dead*, supra.

BIBLIOGRAPHY

Editorial, The Moment of Death, *World Medical Journal*, Sept.-Oct., 1967, p. 133.

Biorck, On the Definitions of Death, *World Medical Journal*, Sept.-Oct., 1967, p. 137.

Muller, Legal Medicine and the Delimitation of Death, *World Medicine Journal*, Sept.-Oct., 1967, p. 140.

Voigt, The Criteria Of Death-Particularly in Relation to Transplantation Surgery, *World Medical Journal*, Sept.-Oct., 1967, p. 143.

Wassermann, Problematical Aspects of the Phenomenon of Death, *World Medical Journal*, Sept.-Oct., 1967, p. 146.

Time Magazine, Medicine, May 27, 1966, p. 78.

Letters to the Journal, *Journal of the American Medical Association*, Vol. 203, No. 10, March 4, 1968.

Eppinger, Die Permeabilelaetspathologie, Wien-Springer, Verlag, 1949.

Timbs, *Mysteries of Life, Death, and Futurity*, 1861, London, Kent & Co.

Kerr, *Forensic Medicine*, A & C Black Co., 6th Edition, 1957.

Pesin and Winter, Organ Transplants; A legal and moral dilemma, *Science Digest*, April, 1968.

Snider, When is a Person Dead, *Science Digest*, Oct., 1967.

Houts, *Courtroom Medicine*, Death, Matthew Bender, 1967.

Rosenfeld, Control of Life: The New Man, *Life Magazine*, Oct. 1, 1965, Vol. 59.

Journal of the Medical Society of New Jersey, Vol. 64, No. 3, March, 1967, p. 100.

Van Dellen, Alive or Dead, *Illinois Medical Journal*, Vol. 132, No. 4, Oct., 1967.

Lear, A Realistic Look at Heart Transplants, *Sat. Review*, February 3, 1968.

Stickel, Ethical and Moral Aspects of Transplantation, *Monographs in the Surgical Sciences*, December, 1966, Vol. 3, No. 4.

American Journal of Nursing, Aug., 1967.◄

401 Euclid Ave.
Greenwood 46142

Drug-Induced Blood Dyscrasias

WEI-PING LOH, M.D.
Gary*

WITH the increasing number and complexity of therapeutic agents, the incidence of drug-induced blood dyscrasias has become impressive, if not alarming. As of December 31, 1962, the Study Group on Blood Dyscrasias of the AMA Council on Drugs published 743 cases (38.8%) of leukopenia and agranulocytosis; 598 cases (31.3%) of aplastic anemia with pancytopenia; 293 cases (15.3%) of thrombocytopenia; 106 cases (5.5%) of hemolytic anemia and 74 cases (3.9%) of erythroid hypoplasia without pancytopenia. The purpose of this paper is to remind and alert physicians to the potential hemopoietic toxicity of many drugs and to provide a quick reference for physicians who are investigating drug-induced blood dyscrasias. Generally the blood dyscrasias may be divided into five main groups:

Group I—Leukopenia and agranulocytosis: Increased peripheral destruction of granulocytes and marrow depression with decrease in granulocytic elements are believed to be the mechanism. Circulating leukoagglutinins or leukolysins may be demonstrated in many drug-sensitive patients. It is postulated that the offending drug combines with a protein in the serum to form an antigen. This causes sensitization and the antibodies thus formed become attached to the leukocytes which are then agglutinated and destroyed when the antibody and the antigen come in contact. Wintrobe classified the offending drugs as shown in Table I.

A large number of drugs which

* Chief Pathologist, Methodist Hospital of Gary; Assoc. Professor of Pathology, Chicago Medical School. This paper was accepted for publication in 1963.

AGENTS ASSOCIATED WITH LEUKOPENIA

A. Agents which regularly produce leukopenia if a sufficient dose is given:
   (1) Ionizing radiation (roentgen rays, radioactive P, Au, etc.).
   (2) Mustards (sulfur and nitrogen mustards, triethylenemalamine (TEM), etc.).
   (3) Urethane, busulfan, Demecolcin.
   (4) Benzene.
   (5) Antimetabolites (antifolic compounds, 6-mercaptopurine, etc.).

B. Agents occasionally associated with leukopenia (granulocytopenia):

Analgesics	Amidopyrine and drugs containing it (amidophen, amytal compound, causaline, cibalgin, neonal compound, neurodyne, peralga, pyraminal, yeast-vite, etc.). Antipyrine, novaldin (Novalgin). Phenylbutazone (Butazolidin).
Antithyroid drugs	Thiouracil, propylthiouracil, methylthiouracil, methimazole, carbimazole.
Anticonvulsants	Trimethadione (Tridione), phethenylate, phenacemide, diethazine, diphenylhydantoin sodium.
Sulfonamides	Sulfanilamide, prontosil, sulfapyridine, salicylazosulfapyridine, sulfathiazole, sulfadiazine, succinylsulfathiazole, sulfisoxazole (Gantrisin), sulfamethoxypyridazine (Kinex).
Antihistaminics	Pyribenzamine, methaphenilene (Diatrin), phenothiazine, thenalidine.
Antimicrobial agents	Organic arsenicals, chloramphenicol, thiosemicarbazone (Tibione), ristocetin.
Tranquilizers	Chlorpromazine and other phenothiazine derivatives (mepazine, promazine, prochlorperazine, etc.).
Miscellaneous	Dinitrophenol, tolbutamide, chlorpropamide, carbutamide (antidiabetic drugs), phenindione (anticoagulant), gold salts, industrial chemicals.

TABLE 1

AGENTS ASSOCIATED WITH MARROW DEPRESSION

A. Agents which regularly produce marrow hypoplasia and aplasia if a sufficient dose is given:

(1) Ionizing radiation (roentgen rays, radioactive P, Au, etc.).

(2) Mustards (sulfur and nitrogen mustards, triethylenemalamine (TEM), etc.

(3) Urethane, myleran.

(4) Benzene.

(5) Antimetabolites (antifolic compounds, 6-mercaptopurine, etc.).

B. Agents occasionally associated with hypoplasia or aplasia (drug idiosyncrasy?):

Class of Compounds	20-100 or more reported cases	Single or few reports
Antimicrobial agents	Arsenobenzols	Inorganic arsenicals
	Chloramphenicol	Streptomycin
		Sulfonamides
		Oxytetracycline
		Chlortetracycline
Anticonvulsants	Mesantoin (Methyl-phenylethylhydantoin)	Tridione (trimethadione)
		Nuvarone (methyl-phenylhydantoin)
Antithyroid drugs		Carbimazole (carbe-thoxythiomethylglyoxaline)
		Tapazole (methylmer-captoimidazole)
Antihistaminics		Pyribenzamine
Insecticides		Chlorophenothane
Miscellaneous agents	Gold preparations	Quinacrine (Atabrine)
	Trinitrotoluene	Dinitrophenol
		Phenylbutazone
		Chlorpromazine and promazine
		Hair dyes
		Meprobamate
		Bismuth
		Mercury
		Colloidal silver
		Carbon tetrachloride

TABLE II

were mentioned only in one or two reports have been omitted from Table I. The more common causes of leukopenia and agranulocytosis today are the antithyroid drugs, especially propylthiouracil, methylthiouracil and methimazole (Tapazole) and the phenothiazine derivatives, notably promazine (Sparine) and chlorpromazine (Thorazine).

Group II—Aplastic anemia with or without pancytopenia: Drug idiosyncrasy and marrow depression are believed to be responsible for this condition. Benzene is particularly offending. Wintrobe also listed agents associated with marrow depression (Table II).

The causal relationship of the aplastic anemia to a drug is often difficult to recognize. Only a small proportion of the patients who receive a drug capable of producing aplastic anemia will be sensitive to it. Pancytopenia may appear only after prolonged administration or repeated courses of the drug. In recent years the most common drug associated with aplastic anemia has been chloramphenicol (Chloromycetin). Chloramphenicol has been observed to cause two types of hematological toxicity: (1) a temporary erythroid hypoplasia, associated with anemia and occasionally with thrombocytopenia and leukopenia and (2) a severe, often fatal, pancytopenia.

Group III—Hemolytic anemia: Important drugs associated with hemolytic anemia are:

(1) Sulfonamides — sulfanilamide, sulfapyridine, sulfathiazole, sulfadiazine, sulfadimidine, salicylazosulfapyridine.

(2) Antimalarial compounds — pamaquin, primaquine.

(3) Phenylhydrazine and many others, such as Fuadin, quinidine and nitrofurantoin.

Sensitivity of the host and sometimes the dose received are important factors. It was found that glucose-6-phosphate dehydrogenase (G6PD) activity and reduced glutathione (GSH) are depleted in the red blood cells of primaquine-sensitive subjects. G6PD deficiency and GSH instability apparently characterize the abnormality which permits hemolytic action of the drug and a number of other chemical agents. In rare cases such as hemolytic anemia produced by Fuadin and quinidine, there is an immune mechanism in which antibodies are formed against a combination of the drug and the erythrocyte. This leads to agglutination and damage of the erythrocytes only in the presence of the drug.

Group IV—Purpura or thrombocytopenia: Thrombocytopenia can be produced through myelosuppressive action of the offending drug or through an immune mechanism in which antibodies are formed against a combination of the drug and the platelets. Individual sensitivity is an important factor. Generally the offending drugs may be classified as follows:

(1) Myelosuppressive agents: nitrogen mustards, TEM, busulfan, urethane, antimetabolites, benzene and radioactive substances.

(2) Agents which in therapeutic doses produce purpura mainly because of individual sensitivity: organic arsenicals, sulfonamides, "Sedormid", quinidine, quinine, chlorothiazide (Diuril), hydrochlorothiazide, gold salts, butobarbitone; and possibly also acetazolamide (Diamox), chloramphenicol, penicillin, chlorophenothane (DDT), meprobamate (Equanil, Miltown), stibophen, oxytetracycline, para-aminosalicylic acid, streptomycin, phenylbutazone, antipyrine, sodium salicylate, tridione, meparfynol, phenobarbital, allylisopropylbarbituric acid, thiourea, dinitrophenol, digitoxin, mercurials, potassium iodide, bismuth, ergot, organic hair dyes, estrogens, tolbutamide (Orinase), chlorpropamide (Diabenese).

Group V—Other blood dyscrasias:

A. Drugs associated with macrocytic megaloblastic anemia:

(1) Folic acid antagonists, such as amethopterin, 6-mercaptopurine and 5-fluorouracil.

(2) Anticonvulsant drugs, such as diphenylhydantoin sodium (Dilantin), primidone (Mysoline) and barbital derivatives (methophenobarbital, amylobarbitone sodium and quinalbarbitone sodium).

The number of cases thus far reported is small. It has been postulated that the offending drugs may act as folic acid antagonists since there is a structural similarity between the drugs and the pterodyl portion of the folic acid. Some unknown predisposing factor may be involved as well. Inadequate diet, especially folic acid deficiency, may be one important predisposing factor.

B. Drugs producing polycythemia:

(1) Cobalt. Cobalt causes true increase in red cell mass and increased erythropoietic activity.

(2) Excessive use of coal-tar derivatives which could produce sulfhemoglobin and methemoglobin.

(3) Other drugs which give unimpressive polycythemia: digitalis, caffeine, nicotine and a number of minerals (manganese, mercury, iron, bismuth, arsenic, germanium), radium salts.

C. Drugs associated with methemoglobinemia: phenacetin, acetanilid, sulfonamides (sulfanilamide, sulfapyridine, sulfathiazole), nitrobenzene, various nitrites (sodium, amyl, ethyl), nitroglycerine, bismuth subnitrate and ammonium nitrate.

Deficiency of methemoglobin reductase can be demonstrated in some of the cases.

D. Drugs associated with porphyria: barbiturates, sulfonmethane

(Sulfonal), sulfonethylmethane (Trional), allylisopropylacetylcarbamide (Sedormid), chloroquine, progesterone.

These drugs can precipitate porphyria attacks.

Summary

The production of a blood dyscrasia by a drug is not usually the result of the pharmacological properties of the drug, but more often a consequence of drug idiosyncrasy. In some types of drug-related blood dyscrasias, the pathogenetic mechanism is understood, while in other types, the mechanism is entirely unknown. In many instances reported, multiple drugs have been given and it is difficult to pin down the offending drug. Table 3 provides a quick reference for drug-induced blood dyscrasias.

The incidence of untoward drug reactions differs with different drugs and with individual patients. The figure varies from less than one percent for one drug to four percent or more for another drug, even in the same category of therapeutic agents. Reactions also vary from an immediate response to one occurring a number of weeks after initiation of therapy. Adequate statistics are not always available.

In management of drug-induced blood dyscrasias, the author would like to recommend a few points:

1. Be aware of the risks of blood dyscrasias associated with the use of all drugs mentioned in this paper and be on the watch for reactions from new drugs.
2. Obtain an adequate history of sensitivity or drug idiosyncrasy if known by the patient and avoid use of the offending drugs.
3. Use the potentially toxic drugs (if indicated) with great care, even when the patient gives no history of drug idiosyncrasy. Use one drug at one time, if possible.
4. When the potentially toxic drug is in use, the patient should receive appropriate hematological studies at suitable intervals. The patient should also be warned to report immediately the development of fever, sore throat, pallor or a bleeding tendency.
5. If agranulocytosis, thrombocytopenia or pancytopenia is present, further administration of the drug must be discontinued.
6. Carry out further studies. When the drug is strongly suspected of being responsible for blood dyscrasia, report your case to the Study Group on Blood Dyscrasias, Council on Drugs, American Medical Association. ◄

SUMMARY OF DRUG-INDUCED BLOOD DYSCRASIAS

Drugs (examples)	Blood Dyscrasias: Leukopenia	Aplastic Anemia	Hemolytic Anemia	Thrombocytopenia
Analgesics (Amidopyrine, Aspirin)	+++	++	+	++
Antithyroid drugs (Thiouracil, Tapazole)	+++	+	0	+
Anticonvulsants	++	+	0	+
Sulfonamides	++	+	++	+
Antibiotics (Chloromycetin)	++	+++	±	+
Antihistaminics	+	+	0	+
Antimalarial drugs	±	0	++	0
Tranquilizers	++	±	0	+
Antidiabetic drugs	+	+	0	+

TABLE III

Let's be specific about Campbell's Soups... and *reducing diets*

There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

SUNDAY
MONDAY
TUESDAY
WEDNESDAY
THURSDAY
FRIDAY
SATURDAY

Ovulen-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

works the way a woman thinks

by weekdays...not "cycle days"

Whether it be "shopping day," "bridge day" or "housecleaning day," a woman is accustomed to thinking in terms of days of the week rather than in "cycle days." Ovulen-21 lets her remember her natural way. Once established, her starting day is always the same day of the week... because it is fixed at three weeks on — one week off and is independent of withdrawal flow.

The same Ovulen in the same low dosage... with the same low incidence of side effects and the same high degree of protection against pregnancy.

Note: Ovulen remains available in the familiar round Compack for those women who may wish to continue to use the traditional 20-day schedule. Be sure to specify Ovulen-21 to assure each new patient of the advantages of the new *Three Weeks On—One Week Off* schedule. She might appreciate your budget-minded authorization for a six-month supply (five Refills).

Indication — For oral contraception.

Contraindications — Thrombophlebitis or a history of thrombophlebitis or pulmonary embolism, liver dysfunction or disease, known or suspected carcinoma of the breasts or genital organs and undiagnosed vaginal bleeding.

Warnings — Discontinue medication pending examination if sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine occurs. Discontinue if papilledema or retinal vascular lesions occur. Since the safety of Ovulen in pregnancy has not been established, rule out pregnancy before a patient who has missed two consecutive menstrual periods continues the tablets. Consider the possibility of pregnancy at the first missed withdrawal flow if the recommended schedule has not been followed. The active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this to the infant has not been determined.

Precautions — The pretreatment physical examination should specifically include the breasts, pelvic organs and a Papanicolaou smear. Endocrine and possibly liver function tests may be affected by Ovulen. Such tests should be repeated two months after stopping the medication if their results were abnormal in a woman taking Ovulen. Pre-existing fibroids may enlarge under the influence of progestin-estrogen preparations. Patients with epilepsy, migraine, asthma, cardiac or renal dysfunction, which conditions might be influenced, require careful observation because Ovulen may cause some degree of fluid retention.

Ovulen should be used with caution in patients with a history of cerebrovascular accident. Nonfunctional causes should be considered if breakthrough bleeding occurs. Adequate diagnostic measures are indicated in women with undiagnosed vaginal bleeding. Carefully observe patients with a history of psychic depression and discontinue the medication if depression recurs to a serious degree. Any possible influence of prolonged Ovulen use on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. Carefully observe diabetic patients during Ovulen use since a decrease in glucose tolerance has occurred in a few such patients. Physicians should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism since such conditions occasionally occur in patients taking oral contraceptives. Use Ovulen judiciously in young patients in whom bone growth is not complete because of the effects of estrogens on epiphyseal closure. Age is no absolute limiting factor, although Ovulen use may mask the onset of the climacteric. Pathologists should be informed of Ovulen use when relevant specimens are submitted.

Side effects — The following adverse reactions have been observed in varying incidence in patients taking oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight (increase or decrease), changes in cervical erosions and secretions, suppression of lactation when used immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals and mental depression.

Although the following side effects have been reported in users of oral contraceptives no cause and effect relationship has been established: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption and itching. Thrombophlebitis, pulmonary embolism and neuro-ocular lesions have occurred in users of oral contraceptives, although a cause and effect relationship has been neither established nor disproved.

The following laboratory results may be altered by oral contraceptives: Bromsulphalein® and other hepatic function tests—increased; coagulation tests, including prothrombin, Factors VII, VIII, IX and X — increased; thyroid function — increase in protein-bound iodine and butanol extractable protein-bound iodine, and a decrease in T^3 values; metyrapone test and pregnanediol determinations.

Dosage and administration — One tablet of Ovulen-21 daily for 21 consecutive days, beginning five days after the onset of a menstrual flow (the first day of menstruation is counted as day 1), then discontinued for one week. If Ovulen is started later than day 5 after menses begins another method of protection is used until the first seven tablets have been taken. Subsequent 21-day courses are begun on the eighth day after the last tablet was taken in the preceding cycle. This three weeks on — one week off schedule is continued whether or not withdrawal flow has begun, flow has ceased or spotting or breakthrough bleeding has been experienced.

If one tablet is missed it is to be taken as soon as it is remembered and the next tablet at the usual time. If two consecutive tablets are missed the dosage is doubled for the next two days, then the regular schedule is resumed. If three consecutive tablets are missed a new tablet cycle is started on the eighth day after the last tablet was taken. For the best protection in the latter two instances instruct the patient to use another method of contraception until the next seven consecutive tablets have been taken. The possibility of ovulation increases with each successive tablet missed.

Postpartum administration — Non-nursing mothers may begin Ovulen immediately after delivery and nursing mothers after lactation is well established.

SEARLE *Before prescribing see Detailed Product Information.*
G.D. Searle & Co., P.O. Box 5110, Chicago, Illinois 60680

Ovulen-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

three weeks on...one week off

In the complex picture of moderate to severe anxiety...

there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

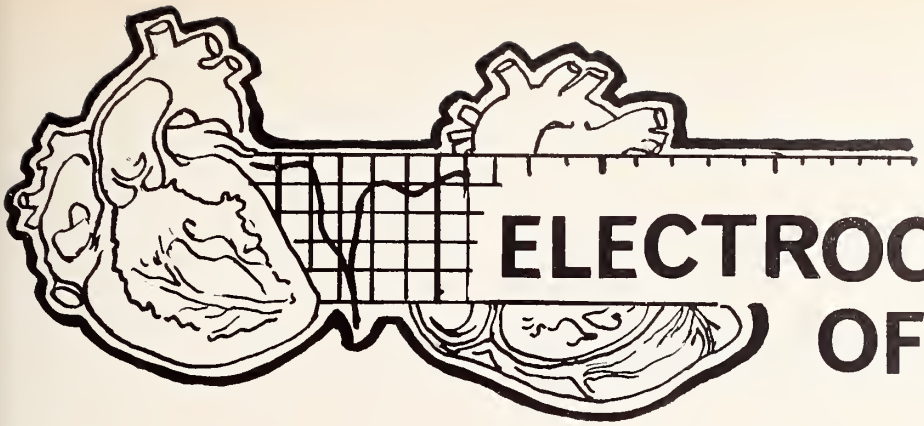
Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl) 25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ

SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-169



ELECTROCARDIOGRAM OF THE MONTH

CHARLES FISCH, M.D.
*Indianapolis**

THE accompanying figure is a composite of precordial leads of four different patients with T wave abnormalities. After you have jotted down your impression of the etiological diagnosis for each of the four cases, please turn the page upside down for the answer.

(Tracings with abnormal T waves were presented in the July, 1968, issue of *JISMA.*)

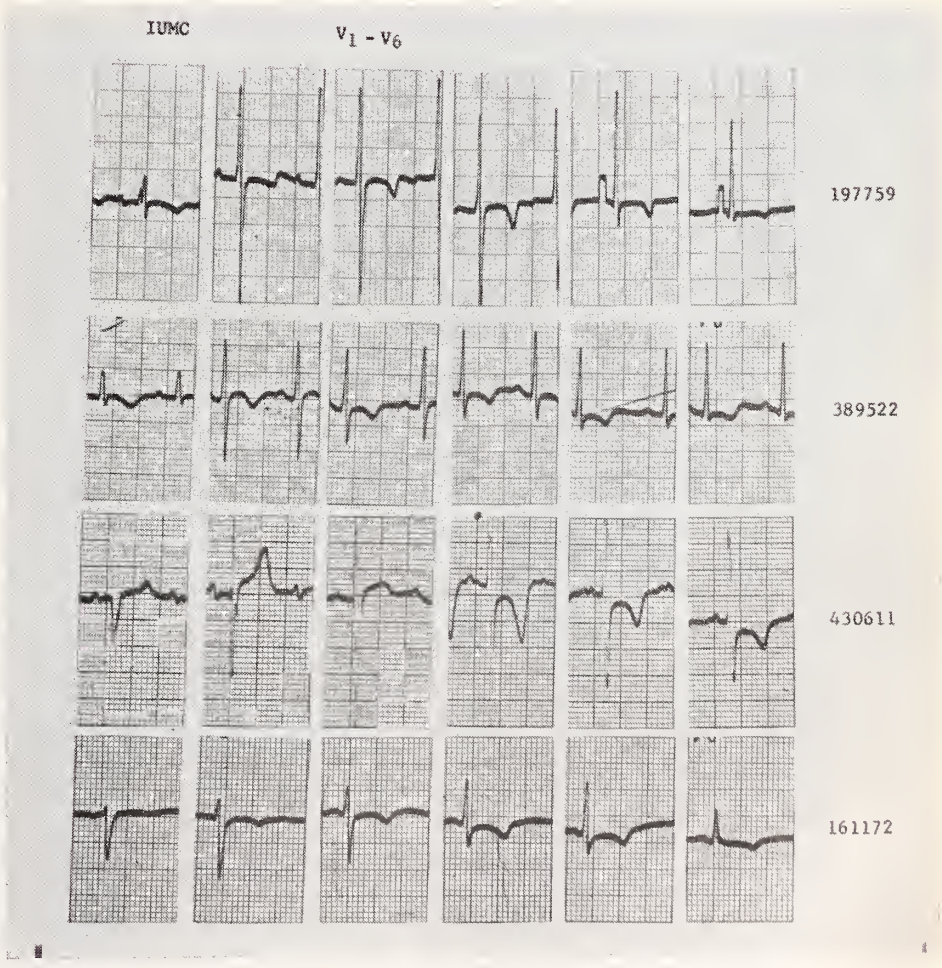


FIGURE 1
197759 — Thalassemia
389522 — Friedreich's ataxia
430611 — Primary skeletal myopathy of undetermined cause
161172 — Brain tumor

* From the Krannert Institute of Cardiology, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.

X-RAY CONFERENCE

Aneurysm of the Abdominal Aorta

ERICH K. LANG, M.D.
*Shreveport, La.**

THIS 58-year-old white male was admitted to Methodist Hospital, Indianapolis, with the complaint of severe abdominal and back pain. Physical examination suggested the presence of a pulsatile mass in the lower abdomen. Pulse amplitude and blood pressure in both lower extremities appeared to be significantly decreased in comparison with the values obtained in the upper extremities. Urine analysis was unremarkable. Neurologic examination showed no significant abnormalities.

A retrograde femoral catheterization of the abdominal aorta was carried out (Figure I). The catheter was advanced under fluoroscopic control into the upper portion of the abdominal aorta and an injection of 40ccs. of Angio-Conray was carried out. The events were recorded on serial films. A blow-out type of aneurysm of the distal abdominal aorta presenting predominently towards anterior and to the right was demonstrated. The aneurysm involved the aorta some two and one-half cms. below the origin of the renal arteries, to approximately one and one-half cm. above the bifurcation. A soft tissue mass did not appear to be associated with the aneurysm, and significant clot formation in the wall of the aneurysm was, therefore, not suggested.

Within 12 hours, the patient was subjected to operative correction. The aneurysm was satisfactorily resected and the patient had an uneventful recovery.

Discussion

Arteriographic demonstration of bleeding or ruptured aneurysms of the distal abdominal aorta is imperative for successful surgical correction of this lesion. Venous antegrade aortography or antegrade catheter aortography with introduction of the catheter into the axillary, brachial, or subclavian arteries have been recommended as safe procedures for the delineation of such aneurysms. In the recent past, retrograde catheterization through such aneurysms has been satisfactorily and safely performed, if the femoral pulse at the point of entry for the catheter was readily discernable and palpable.

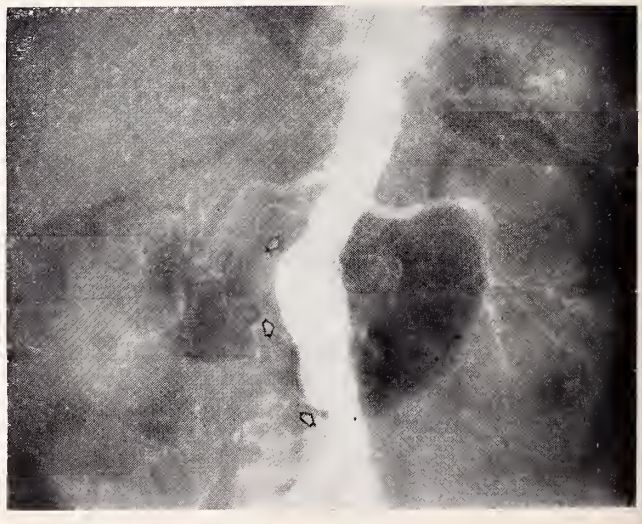


FIGURE 1

A retrograde catheter arteriogram, with the tip of the catheter placed at the level of D-12-L-1, demonstrates a fusiform blow-out type of aneurysm involving the right lateral and anterior wall of the abdominal aorta. The aneurysm commences some 2cms. below the origin of the renal arteries, and extends to approximately 1 and ½cm. above the bifurcation (arrows). Arteriosclerotic changes of the abdominal aorta and iliac arteries are noted.

* From the Department of Radiology, Louisiana State University School of Medicine, Confederate Memorial Center, Shreveport 71106. Dr. Lang formerly was at Methodist Hospital, Indianapolis.

The technic utilizes a routine percutaneous Seldinger approach. The femoral artery is punctured; a guidewire is introduced through the outer sheath of the needle, and advanced in a cephalad direction. A J-shaped guidewire with a highly flexible tip is utilized in cases of a suspected aneurysm of the distal abdominal aorta, and the guidewire is advanced with a 15 to 30cm. lead segment ahead of the catheter. A J-shaped and highly flexible guidewire tip safeguards against perforation of the weakened aneurysm wall, and permits easy bypassing of an intra-aortic blood clot that may be lining the wall of the aneurysm. Once the flexible J-shaped tip of the guidewire has been advanced into the lower thoracic aorta, the catheter can then be threaded with great safety to the appropriate level. If a pressure injection should be carried out, the catheter tip should be positioned one to two inches above the level of the aneurysm. The level of the aneurysm can be ascertained by hand injection of small amounts of contrast material, monitored fluoroscopically or on scout films.

This method of retrograde catheterization through an aneurysm has been found safe in some 22 patients, where we chose to employ this diagnostic modality. The speed of the procedure and the improved detailed visualization emphasizes the advantage of this procedure over antegrade venous aortography. The lack of complications favor this method over brachial or axillary artery catheterization.

The method is, therefore, recommended for its speed, ability of high detail demonstration of the lesion, and relative safety if performed with the precaution of utilizing a highly flexible J-shaped guidewire. ◄

When the problem is only skin deep

USE 'POLYSPORIN'® brand POLYMYXIN B-BACITRACIN OINTMENT

for topical antibiotic therapy with minimum risk of sensitization

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

Supplied in ½ oz. and 1 oz. tubes.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.

FRACTURES AND ORTHOPEDIC PROBLEMS

"Fractures and Orthopedic Problems" is a feature which will appear regularly. It will outline conditions involving bones and joints which will be of interest to physicians in general and special types of practice. It will be edited by George F. Rapp, M.D. of Indianapolis. The submission of short illustrated articles to this feature is invited.

The Fingertip Injury—An Evaluation of Treatment

JAMES W. STRICKLAND, M.D.
*Indianapolis**

FINGERTIP injuries represent a frequent traumatic condition which, if improperly treated, can result in significant deformity and disability. The physician treating these injuries must select a method which can best preserve tactile sensation, maximum length and joint motion, while providing a satisfactory appearance with minimal tenderness. Unfortunately, inadequate patient follow-up often prevents a thorough appreciation of the long-term performance of the methods used in repair.

Fractures of the distal phalanx, fingertip infections and nail avulsions are treated by well known and effective measures and will not be considered here. Details of surgical technic are omitted as they are well described in numerous standard references.

This discussion is limited to the treatment of avulsions of the tactile finger pad** and offers no new methods but suggests the most practical and reliable of the many current technics and attempts to clarify the indications of each.

* From the Department of Orthopaedic Surgery, I.U. School of Medicine, 1100 W. Michigan St., Indianapolis 46202.

** For purposes of clarity, we will refer to the "finger pad" as that portion of the volar finger distal to the distal interphalangeal crease, and the term "pulp" will refer to the subcutaneous tissue within these boundaries.

Factors

The age of the patient, the size, shape and location of the defect, and the viability of partially detached tissue are important factors in the management of finger pad avulsions. Children under six have remarkable regenerative powers while persons over 60 do not tolerate grafting procedures and immobilization well.[1,2,15,27] Both groups should receive the most simple repair consistant with rapid healing and minimal deformity.

The digit and the hand involved and the socio-economic status of the patient are frequently mentioned as important factors in the selection of a method of repair.[1,2,5,12] It is our contention, however, that although the ulnar three digits are of less functional importance than the thumb and index, they are nonetheless of considerable value to the tactile integrity of the hand and should be treated with equal concern. Further, we concur with Flatt[15] that no matter what the patient's occupational or financial status, he should be offered the operation that will come closest to restoring a normal finger. Sacrificing this principle in order to get the soldier back to the battle or the farmer back to the field does not seem consistent with a clear surgical conscience.

In limiting discussion to the large number of fingertip injuries between the ages of six and 60 and by exclusion of the position importance of the digit involved and the socio-economic status of the patient, we will consider only the nature of the defect as the primary factor in determining the method to be employed in repair.

Methods of Repair

The types of finger pad repair are:[1-28]

1). No treatment—healing by secondary intention.

2). Replacement of detached tissue and composite grafts.

3). Primary closure with local flaps.

4). Free split thickness grafts.

5). Free full thickness grafts.

6). Cross finger pedicle flaps.

7). Thenar pedicle flaps.

8). Remote pedicle flaps.

Neurovascular island pedicle flaps have little, if any, application to acute fingertip injury and will not be discussed.

In evaluating the various methods we rely heavily on the work of Sturman and Duran,[25] who reported on the late results of 235 tactile pad avulsions with careful correlation of

results with the methods used in repair.

Sturman and Duran found that the results of cross-finger and palmar flaps were superior to other methods in sensory and functional return. Patients with cross-finger repairs in particular had fewer complaints of tenderness, cold sensitivity, poor touch, impaired size and texture discrimination and disability when performing intricate tasks. Avoidance of thumb and index use when repaired by these procedures was minimal as compared to the high percentage in those repaired by other methods.

More than 50% of patients with free full and split thickness grafts, abdominal pedicle flaps, and primary repairs had tenderness, cold sensitivity and disability in daily activities. Objective testing of two point discrimination, weight to produce pinprick and resultant pigmentation showed comparable results in repairs by all methods, but the authors state that cross-finger and thenar flaps demonstrated more normal testing. As would be expected, the number of days lost to injury and repair was substantially higher in the three pedicle flap procedures. Free full thickness grafts and abdominal pedicle flaps were found to give the most consistently undesirable results.

Sturman and Duran concluded that "when an extensive tactile pad avulsion exists, the cross-finger pedicle flap offered the best long term result despite the fact that more time was lost from work during the period of repair."[25] Although we are essentially in agreement with this thorough study, it should be noted that it was not possible for the authors to correlate the size or depth of the initial lesion with the method used in repair. We feel that the nature of the defect is of prime importance in determining the type of treatment to be employed and consequently, no single repair can be judged best for all fingertip avulsions.

Our evaluation of the methods of finger pad repair is as follows:

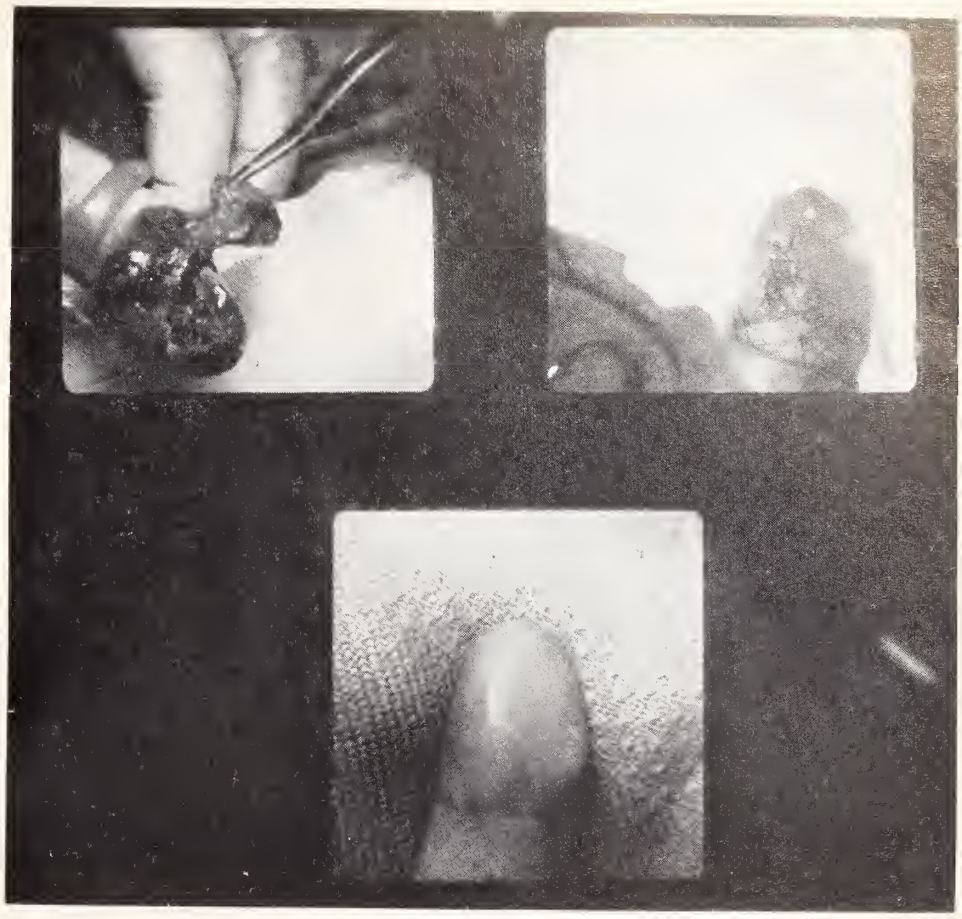


FIGURE 1

RAGGED, incomplete avulsion of the thumb pad with viable traumatic flaps. Minimal debridement and careful replacement of tissue resulted in a satisfactory functional and cosmetic result at six months.

1). *No Treatment—Healing by Secondary Intention:* Simple dressing without attempt at coverage must be reserved for small, superficial losses which can be expected to epithelialize spontaneously.[28] In larger lesions this method is condemned as it will result in prolonged healing, chronic infection and a tender, adherent scar.[2,4]

2). *Replacement of Detached Tissue and Composite Grafts:* The replacement of cleanly severed tissue as a composite graft[13,28] is rarely successful despite careful defatting and meticulous replacement.[1,9] The frequent failure of this technic compounds the initial injury by delay in closure and often, subsequent infection.[9] Composite grafts from the toe[21] and ear lobule[8] are dramatic procedures, but are rarely practical. These repairs should be reserved for ideal circumstances when other more reliable methods are precluded.[9]

3). *Primary Closure with Local Flaps:* Incomplete tip avulsions may present with traumatic flaps sustained by vascular pedicles. Minimal debridement and meticulous replacement of this tissue will often result in an excellent finger pad (Figure 1).[9]

The use of specially fashioned local flaps as advocated by Bunnell,[6] Kutler,[20] and more recently Fisher,[14] have the disadvantages of some digital shortening and a healing delay in the event of flap failure. These procedures are technically more difficult and less reliable than free split grafting in the type of distal tip amputation for which they are recommended.

Local tissue closure necessitates shortening of bone and therefore results in some degree of disability. The incidence of post-recovery tenderness and cold sensitivity is high. This procedure is indicated when

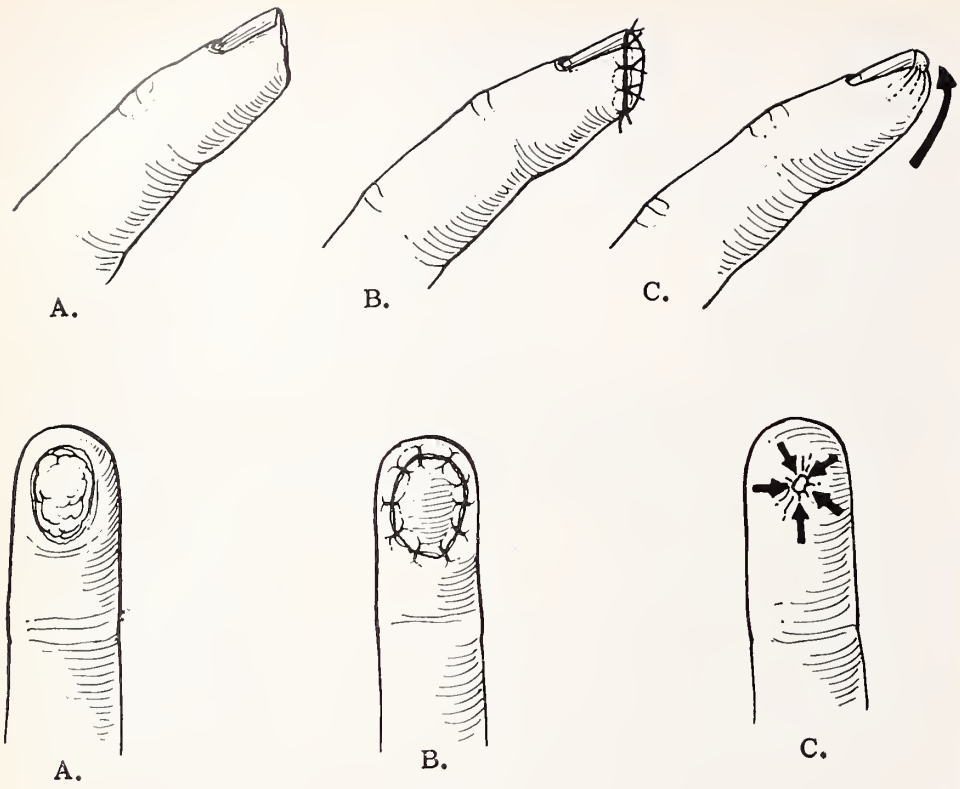


FIGURE 2

GRADUAL contracture of the split thickness skin graft will result in migration of the normal finger pad towards the dorsum in distal tip lesions and circumferential closure of defects of the central finger pad.

FIGURE 3

GUILLOTINE amputation of the tip of the long finger. Split thickness coverage was provided and resulted in a gradual shrinkage and dorsal migration of the normal pad.

there is considerable destruction of dorsal structures or when most of the distal phalanx has been traumatically amputated.[1,7,10] It is also the preferred procedure when there is a significant amount of exposed bone with inadequate soft tissue for repair.[12]

4). *Free Split Thickness Grafts:* This method is of considerable value in defects involving less than 50% of the finger pad. The advantage of split thickness coverage in these lesions lies in the ultimate contracture of the graft (Figure 2).[1,5,9,24] On the repaired distal tip, this shrinkage will result in migration of the fingertip pad towards the dorsum and, in avulsions involving less than 50% of the central finger pad, contraction of the split graft results in gradual circumferential closure of the defect with skin of normal sensation and appearance (Figures 3, 4). The resultant deformity is often barely recognizable with essentially normal skin coverage and this is superior to any type of pedicle coverage.[5,9] Split thickness skin grafting is a simple procedure with a high success rate and early spontaneous healing of the donor site. Finger length and joint motion are preserved and patients can return to full work considerably faster than those treated by any other method.[5]

5). *Free Full Thickness Grafts:* Full thickness grafts have no significant advantages over split thickness grafts. The degree of contractability is unpredictable, failure of "take" is more frequent, and the grafted area has a high incidence of tenderness and poor touch sensibility which results in avoidance of use.[24,25] The recommended use of this graft in cases with large skin loss and little subcutaneous involvement has not been verified by our experience and pedicle procedures have given better results. Full thickness grafting, therefore, is not considered as a preferred method of finger pad treatment.[2]

6). *Cross-finger Flaps:* In large tactile pad avulsions, especially when there is exposure of phalangeal bone, this method provides the most consistently satisfactory results.[25] It is an extremely versatile procedure which often provides tactile sensation which approaches normal and gives the lowest incidence of tenderness and disability.[1,2,17,18,23,25] The percentage of success is high and the cosmetic appearance of both the grafted and the donor area is usually satisfactory (Figure 5).[11,17,23,26]

7). *Thenar Flaps:* While generally not as satisfactory as cross-finger pedicles, thenar flaps provide adequate coverage.[16,25] They are especially useful in injuries where a cross-finger procedure is not possible because of concomitant injury to prospective donor areas. The disadvantages of this procedure are the residual defect in the palm and digital joint stiffness following immobilization.[2,3,15,25]

8). *Remote Flaps:* As has been mentioned, distant pedicle flaps usually provide the most unsatisfactory form of coverage.[25] The usual indication for these procedures is multi-digit injuries where pedicle coverage is desirable but local donor areas are not available.[1,2,12] Repair may be obtained by remote flaps from the opposite arm, the anterior chest wall, or the medial thigh to obtain hairless skin coverage with a position of comfort during immobilization.

FIGURE 4
THIRTY percent avulsion of the central thumb pad. Split thickness skin graft with circumferential contracture and minimal defect at four months.

Discussion

The surgeon treating injuries of the tactile finger pad is faced with a wide range of possibilities for repair. A method selected purely to facilitate early wound healing without consideration for long term performance will often result in a poorly sensitive, painful and unsightly fingertip. In reviewing the various methods currently employed in the treatment of the finger pad lesion, it is apparent that several repairs are superior with regard to long term performance and should be emphasized.

The free split thickness skin graft, because of its quality of contractability, is the procedure of choice in the large number of fingertip injuries which involve less than 50% of the finger pad surface and are mainly superficial.[5,12] For larger lesions the split graft shrinkage cannot be expected to satisfactorily approximate normal sensory skin and a scarred, disabling tip may result. In these more extensive avulsions, particularly with exposure of phalangeal bone, cross-finger pedicle repairs are of significant value and can offer a very acceptable replacement of large amounts of pulp substance.[5]

If the surgeon can perfect these two relatively simple technics and apply them according to the amount and depth of pad avulsion, he may be confident that he is providing a repair that will offer a satisfactory long term result.

From these appraisals there have evolved a set of guidelines for the repair of finger pad avulsions. While it is admitted that each case must be considered as an individual problem and methods varied accordingly, we believe that these general principles have been helpful in simplifying the plethora of conflicting advice. We have chosen to refer to these principles as the 50-50 system for finger pad repair.

Principles

1). Treat all fingers alike regardless of digit or hand.

2). Viable local tissue should be carefully preserved.

3). Defects of less than 50% of the surface of the finger pad should be treated with free split thickness grafts.

4). Extensive defects of more than 50% of the finger pad should be

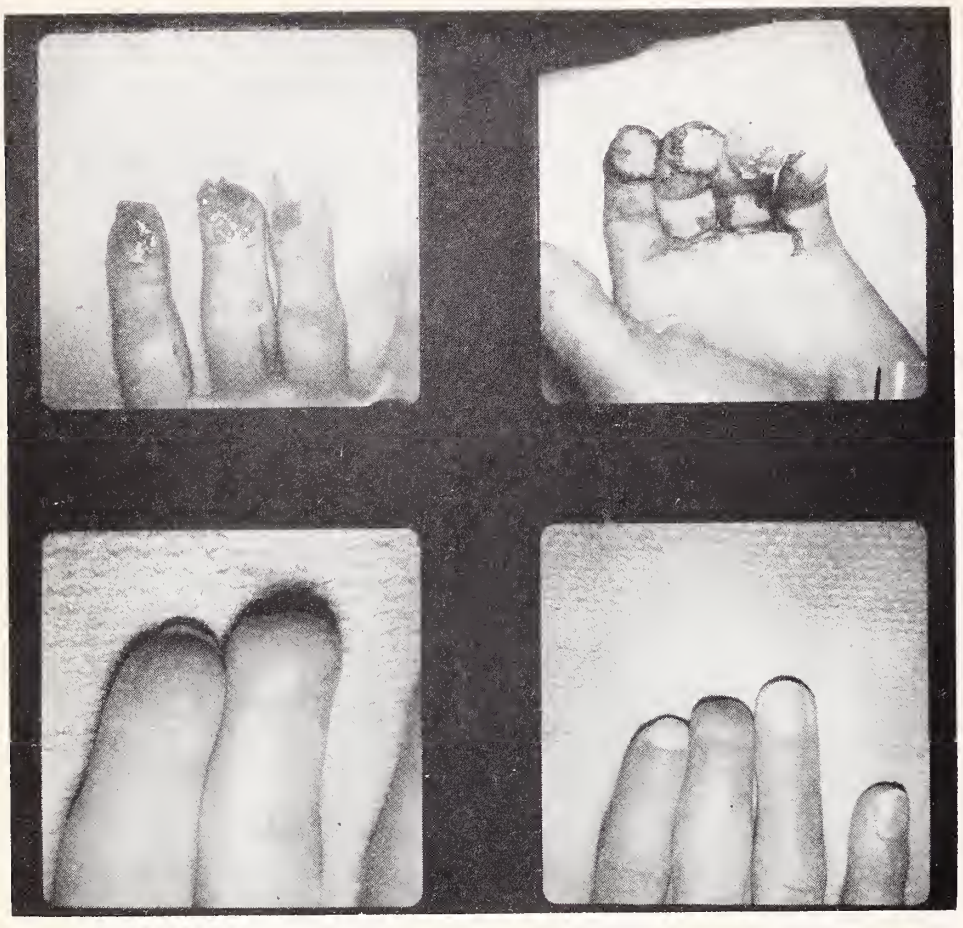


FIGURE 5

SIXTY-FIVE percent avulsion of the pad of the index finger, 80% avulsion-amputation of the long finger and 20% superficial avulsion of the ring finger. Cross-finger flaps were taken from the dorsum of the corresponding long and ring fingers and the ring tip was treated with a split thickness graft. Appearance of the grafted tips and donor areas at five months.

treated with local pedicle flaps, preferably cross-finger flaps.

5). Defects with considerable exposed bone and significant destruction of the dorsal phalanx should be treated with shortening and local repair.

Application of these principles is depicted in Figure 6.

Summary

The current methods employed in the treatment of injuries to the tactile finger pad are reviewed. Emphasis is given to the repairs which most reliably provide a fingertip which approaches normal with minimal deformity and disability. Simplification of the indications for these procedures has been attempted with guidelines offered in accordance with the experience of the author, and the published findings of others.

REFERENCES

1. Bennett, James E.: Finger Tip Avulsions, *J. of Trauma* 6:249-261, Mar., 1966.
2. Byrne, M. B., Clarkson, Patrick: Traumatic Amputation of the Fingertips, *Hand Surgery*, J. Edward Flynn Ed., Baltimore, Williams and Wilkins, 1966.
3. Boyes, J. H.: *Bunnell's Surgery of the Hand*, Philadelphia, J. P. Lippincott, & Co., 1964.
4. Braver, S. D.: Finger Tip Injuries, *Ohio State Med. J.* 60:30-43, 1964.
5. Brody, G. S. Cloutier, A. McL., Woolhouse, F. M.: The Fingertip Injury—An Assessment of Judgment and Management, *Plast. Reconstr. Surg.* 26:80-90, 1960.
6. Bunnell, S.: *Surgery of the Hand*, Ed. 3, p. 65, Philadelphia, J. P. Lippincott & Co., 1956.
7. Burnham, Preston J.: Amputation of the Upper Extremity, *CIBA Clinical Sympos.* Vol. II, No. 4., Fall, 1959. (Illustrations by V. Netter.)
8. Clarkson, P.: Composite Ear Lobe Grafts in the Repair of Traumatic Amputations of the Fingertips, *Guy's Hosp. Gazette* 27, Aug., 1949.
9. Chase, Robt. A., Laub, Donald R.: The Hand, Therapeutic Strategy for Acute Problems, *Current Problems in Surgery* 27-31, June, 1966.
10. Clifford, R. H.: Evaluation of Three Methods of Finger Tip Injuries, *Arch. Surg.* 65:464-466, 1956.
11. Curtis, Raymond M.: Cross-Finger Pedicle Flap in Hand Surgery, *Ann. Surg.* 145:650-655, 1957.
12. Dingman, Reed O., Grabb, William C.: The Common Fingertip Injury, *Mich. Med.* 63:555-557, 1964.
13. Douglas, B.: Successful Replacement of Completely Avulsed Portions of Fingers as Composite Grafts, *Plast. Reconstr. Surg.* 23:213-225, 1959.
14. Fisher, R. H.: The Kutler Method of Repair of Fingertip Amputations, *J. Bone and Joint Surg.* 49A:317-321, Mar., 1967.
15. Flatt, A. E.: *The Care of Minor Hand Injuries*, St. Louis, C. V. Mosby Co., 1963.
16. Horn, J. S.: The Use of Full Thickness Hand Skin Flaps in the Reconstruction of Injured Fingers, *Plast. Reconstr. Surg.* 7:463-481, 1959.
17. Hoskins, H. Dean, Curtis, Raymond M.: Versatility of Cross-Finger Pedicle Flap, *Proc. Am. Soc. for Surg. of the Hand, J. Bone and Joint Surg.* 41A:778, June, 1959.
18. Howard, L. D. Jr.: *Plastic Procedures in Hand Surgery*, 1963, Manual Distributed at Instructional Courses - American Academy of Orthopaedic Surgeons.
19. Koch, S. L.: The Workingman's Hand, *Proc. Am. Coll. of Surgeons* 38:4-13, 1953.
20. Kutler, William: A New Method for Finger Tip Amputation, *JAMA* 133:29-30, 1947.

21. McCash, C. R.: Toe Pulp Free Grafts in Finger-Tip Repair, *Brit. J. Plast. Surg.* 11:322-328, 1959.

22. Metcalf, William, Whalen, W. P.: Salvage of the Injured Distal Phalanx—Plan of Care and Analysis of 369 Cases, *Clin. Orthopaedics* 13:119-123, 1959.

23. Nichols, H. M.: *Manual of Hand Injuries*, Ed. 2, Chicago, Year Book Publishers, 1960.

24. Rank, B. K., Wakefield, A. R.: *Surgery of Repair as Applied to Hand Injuries*, Edinburgh and London, E. and S. Livingston LTD., 1960.

25. Sturman, M. J., Duran, R. J.: Late Results of Finger Tip Injuries, *J. Bone and Joint Surg.* 45A:289-298, 1963.

26. Tempest, M. N.: The Emergency Treatment of Digital Injuries, *Brit. J. Plast. Surg.* 7:153-161, 1954.

27. Wakefield, A. R.: Hand Injuries in Children, *J. Bone and Joint Surg.* 46A:1226-1234, 1964.

28. Webster, G. V.: Treatment of Finger-tip Amputation, *Postgrad. Med.* 8:416-419, 1950. ◄

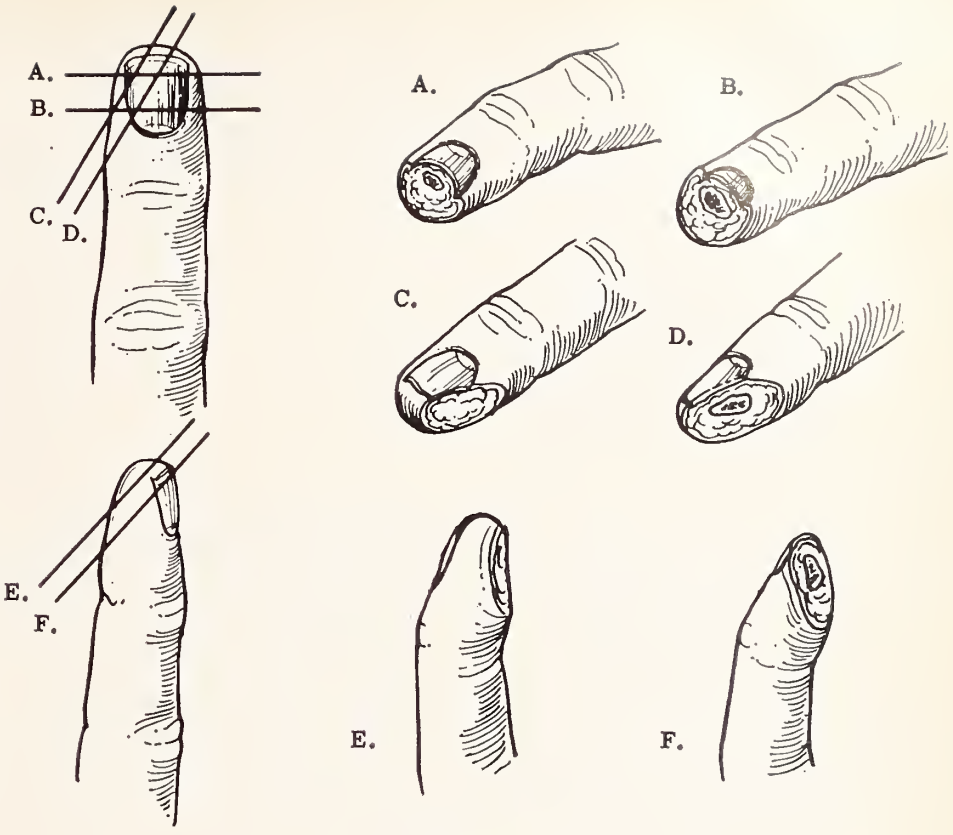


FIGURE 6

A variety of fingertip lesions are shown with the recommended method of repair (Modified from Bennett).

Figure A. Guillotine amputation of distal tip. Thin split thickness skin graft with contraction and dorsal migration of the pad expected.

Figure B. Guillotine amputation of mid-phalanx with 50% pulp loss. Local pedicle flap, preferably cross-finger.

Figure C. Thin oblique tip amputation involving 15% of the finger pad. Free thin split thickness graft.

Figure D. Deep oblique tip amputation with 50% loss of volar and lateral finger pad. Local pedicle flap preferably cross-finger. If exposed bone and nail bed loss are great, excise nail bed and use primary closure with local flap.

Figure E. Forty percent superficial loss of tactile pad. Free split thickness graft.

Figure F. Fifty percent loss of pad with considerable deep pulp loss. Cross-finger flap.

Seminar on Pediatric Neurology

The Pediatric Section of the Methodist Hospital, Indianapolis, will conduct a seminar on Pediatric Neurology on Wednesday, September 18, at the hospital. Guest discussants will be: Arthur Drew, M.D., Professor of Neurology, Indiana University School of Medicine; Paul Dyken, M.D., Associate Professor of Neurology, Indiana University School of Medicine and James Schwartz, M.D., Associate Professor of Pediatrics (Neurology), Emory University School of Medicine. Attendance will be limited. Early registration is advised. Write Gabriel J. Rosenberg, M.D., Methodist Hospital, Indianapolis 46202.

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 1802 North Illinois Street, Indianapolis, Ind. 46202.

Associate Editors: A. W. Cavins, M.D., 221 South Sixth Street, Terre Haute; Lall G. Montgomery, M.D. Ball Memorial Hospital, Muncie; David A. Bickel, M.D., 515 Odd Fellows Building, South Bend, Samuel R. Mercer, M.D., 702 Medical Center Bldg., Fort Wayne; I. W. Wilkens, M.D., 1743 Shelby St., Indianapolis

Editorial Board:	Term Expires
Alvin J. Haley, M.D., Fort Wayne	Dec. 31, 1968
Wei-Ping Loh, M.D., Gary	Dec. 31, 1968
Jack W. Hickman, M.D., Indianapolis	Dec. 31, 1969
Frank H. Coble, M.D., Richmond	Dec. 31, 1969
Jene R. Bennett, M.D., South Bend	Dec. 31, 1970
W. D. Snively, Jr., M.D., Evansville	Dec. 31, 1970

Assistant Editor: Jackie Freers Stahl
Business Manager: James A. Waggener
3935 N. Meridian, Indianapolis, Indiana 46208.

Are We Well Fed? Who Knows?

WHEN famine afflicts large areas of the world and the United States exports grain by the millions of tons there is a tendency to think of Americans as being well fed.

This may be so if the answer is that we have enough total calories for everyone. However, having the calories is not enough. Optimum nutrition is provided only when every individual receives enough calories, but not too many calories, and also receives all the nutritional necessities in proper proportion.

As a matter of fact, although there is ample evidence to indicate that many Americans are poorly fed, there is also a great need for more explicit information on the extent and nature of malnutrition in our country.

Cortez F. Enloe, Jr., M.D., Editor of *Nutrition Today* discusses the subject editorially in his March, 1968, issue.

Dr. Enloe feels that research on nutrition is not directed toward the main problem and that, if the time and money which we devote to the subject was better utilized to produce practical solutions, we would be a lot better off. "It's time to re-examine some of the goals of nutrition research in America," he said.

Dr. William H. Stewart, Surgeon General of the Public Health Service, has pointed out that while we have been conducting nutrition surveys all over the world, "We do not know the extent of malnutrition anywhere in the United States." The Secretary of Health, Education and Welfare is organizing a study of nutrition in some poverty areas but this will only be a start.

Malnutrition is not limited to the financially impoverished. One of the dietary problems the nation faces is the lack of breakfast—the day's most important meal. This one deficiency in particular is common among seven-and eight-year-old school children, some of whose parents could buy the food market and some of whom may even own it.

Children and teenagers are probably affected physically and intellectually by faulty nutrition more than are adults. Despite this, a recent well organized study of the nutritional status of teenagers was halted when half finished because of lack of funds.

Obesity is a widespread nutritional disease—little understood and so ineffectively treated by physicians as to have become the concern of quacks and charlatans.

Dr. Enloe mentions the dearth of knowledge about the dietary problems of old age, and feels that, with the large amount of money spent for Medicare, we should have more knowledge of the dietary rules in the elderly.

While malnutrition can and at times does afflict people in all financial brackets, the association of poverty, undernourishment and illiteracy is well known. Is there a cause and effect relationship between slowness to learn and faulty nutrition? Which comes first? Are dunces made by poor eating, or do they eat poorly because they can't reason well?

Answers are needed to these and other questions. Dr. Enloe thinks that nutritional research is another one of those things which should begin at home.

Two Mailings

THE first mailing that the old grouch checked over was from the Student Health Organization of Chicago. This group is composed primarily of medical students and students in other health professions. The literature that he received from S.H.O. outlined for him their activities and interests in:

1. Abortion law reform.
2. A "high school intern" program to interest youths in

health activities.
3. The war in Vietnam.
4. Medical school curriculum revision.
5. Improving urban health conditions.

The old grouch remembered that the S.H.O. has been condemned roundly by individual physicians and medical organizations.

The second mailing was from Edward R. Annis, M.D., (a form letter signed "Cordially") asking him to join the American Professional Practice Association. Membership in this organization promised him:

1. A $25,000 unsecured loan plan.
2. Group accident and health insurance.
3. Professional advice regarding tax savings, money management, etc.
4. An exclusive plan to purchase any American made car at $150 over dealer's cost.
5. 40% discount on B.F. Goodrich tires.
6. Preferential service and reduced rates at all Ramada Inns.
7. Charter flights at reduced rates to "Vacation areas and centers of learning."

The old grouch grumbled that it would be practically un-American to condemn The American Professional Practice Association.—J.W.H.

"a Disese cald Milksick"

ONE would be hard pressed to find a better example of the truism that disease heavily influences history than that of milk sickness, which vied with malaria and Asiatic cholera as a killer of pioneers.

Milk sickness caused people to flee in terror from many towns and villages in the Midwest and Upper South during the eighteenth and nineteenth centuries. At times it even threatened to halt the westward migration. It caused Abraham Lincoln to move from Indiana to Illinois, thus setting him on the fateful path to fame, an assassin's bullet, and a place in the hearts of his countrymen. Surely he would have given a good account of himself had he stayed in Indiana; it appears highly improbable that he would have been caught up in the swirl of events that carried him to the Presidency during a period of great national peril.

"The milksick," the pioneers' term for milk sickness, killed Lincoln's mother, his great aunt, great uncle and two neighbors in the span of six weeks. And so the Lincoln clan, like many other settlers, fled the lush, rolling hills of Southern Indiana. Lincoln's cousin, Dennis Hanks, explained the move many years later: ". . . we war perplext by a Disese cald Milksick. . . . I was determed to Leve and hunt a Cuntry whare the milk [sick] was not [present]. . . . we Riped up Stakes and Started to Illinois."

For perhaps two centuries, milk sickness baffled the medical profession. The perverted physiology is simple, though deadly, consisting of profound acidosis caused by drinking the milk of a cow that had eaten heavily of the white snakeroot—a pretty flowering weed with a gentle aroma of lilacs. That the weed caused the illness was long suspected but not widely known until well into the nineteenth century. Only in 1963 did scientific evidence appear that the deadly element of milk sickness is a savagely resistant acidosis that induces the pathologic changes previously observed in the heart, brain, intestines, kidney and liver.

With death a certainty in a severely poisoned person, no wonder the plague caused a panic in many localities of Middle America during the eighteenth and nineteenth centuries. Had the pioneers included a litany in their religious services, it might well have begun, "From the terrors of the milksick, Good Lord, Deliver Us!"

When I addressed the Fifty Year Club at the annual meeting of the Illinois State Medical Society during this Illinois Sesquicentennial Year, I had the good fortune to meet a Dr. Mark Greer, who has practiced in Vandalia for 55 years. Dr. Greer had seen much milk sickness during his practice and recalled one chilling incident which occurred in 1921. He saw a family in which the mother had died two days before of the disorder, a 16-year-old girl lay unconscious, two boys were seriously ill, while the father and two other boys had just recovered from mild attacks. Dr. Greer found the girl's temperature subnormal, her knee jerks weak, her eyes glazed and fixed, her intestinal tract atonic. The boys had subnormal temperatures, obstipation and general malaise. All had become gradually ill, lost their appetites, vomited, suffered abdominal pain, became constipated, had coated and swollen tongues. The girl died the next morning. The boys recovered but, for months, became exhausted with the slightest exertion. (The pioneers called this widely recognized after effect of milk sickness, "the slows." Abraham Lincoln used the term in referring to McLellan when he discharged him. The colloquialism is still heard occasionally.)

Dr. Greer's vivid account brought home to me, as reading had never done, the horror of the milksick. I could better understand why the pioneers usually denied that the milksick had ever occurred in their neighborhood—up the river maybe, in the next valley, maybe, over the ridge maybe, but never in their settlement.

Although doctors had been seeing pioneers with the milksick since before the American Revolution, and although hundreds of papers have been written on it, a surprising number of questions remain unanswered. Why did it take the medical profession so long to learn the cause of the disease? (Perhaps it was sporadic, occurring only in drought years, and then limited to rural areas.) Why was the ailment common in some areas, killing one in five of the settlers, yet

absent from other localities that had just as much snakeroot? (It seems highly likely that there are subvarieties of white snakeroot, some of which are completely innocuous although closely resembling the toxic Eupatorium urticaefolium.) Milk sickness is unusual in humans today, but just how unusual? (Since the disease probably occurs undiagnosed, this question may be impossible to answer at the present time.)

Milk sickness occurs in animals, chiefly cattle, during drought years but, again, we don't know the incidence. (A careful, statistical search might prove helpful.) We know that the rayless goldenrod, a desert plant growing in alkaline soil, also causes milk sickness synonymous with alkali fever. What is the incidence in man and animal in Arizona, New Mexico and Mexico? (No figures are available. A study seems indicated.)

Still something of a "riddle wrapped in a mystery inside an enigma," the strange saga of the milksick must fascinate the student of medical history; it offers useful lessons for today's practitioner. **—W. D. Snively, Jr., M.D., Evansville.**

Guest Editorials

Venereal Disease Problem

DURING the past six years there has been a steady increase in reported cases of venereal disease in Indiana. In evaluating the incidence of any disease, those reviewing the statistics must try to determine if there is a true increase or an apparent increase due to better reporting. For 1967 the rise in infectious syphilis cases (primary and secondary) is two cases per 100,000 (23.2 to 25.2). This is serious considering that nationally, the case rate fell from 11.6 to 10.8 per 100,000. Gonorrhea increased in Indiana from a case rate of 85.2 in 1966 to 108.2 per 100,000 in 1967. The national rate on gonorrhea in 1967 was 193 per 100,000.

Hopefully the increase in Indiana may be due to better reporting. This is the reason for the present venereal disease survey being conducted by the American Medical Association. The last survey was done in 1962. The results based on the questionnaires returned by Indiana physicians indicated that they reported only 1.4% of the primary and secondary syphilis treated and 5.9% of the gonorrhea treated.

Last year 43% of the infectious syphilis and 65% of the gonorrhea was reported in the 15-24 year age group. With the ever increasing number of illegitimate births, as an indicator of promiscuity, it follows that venereal disease will continue to rise. The necessity of prompt reporting of infectious venereal disease is essential to rapid contact investigation to assure all sex contacts are examined and treated if found infected.

The cooperation of all physicians in filling out the simple questionnaire requested by the American Medical Association is urged. In this manner a better understanding of the true magnitude of the problem will be revealed.**—A. L. Marshall, Jr., M.D., Indiana State Board of Health, Indianapolis.**

Nation of the Physically Unfit

VICE PRESIDENT Humphrey recently cited facts and figures which should send every American running to the nearest sports club or YMCA, or at least jolt him out of the easy chair in front of his television set.

Speaking to the new President's Council on Physical Fitness and Sports, of which he is Chairman, Mr. Humphrey reported that:

*One of every two American adults is overweight, according to estimates by the American Medical Association;

* 50% of America's college students—young men and women in their late teens or early twenties—fail to meet accepted physical fitness standards; and

* The average American youngster spends 10 hours watching TV for every hour he spends in supervised sports or physical activity.

As a way of getting Americans of all ages to be more active and fit, the Vice President has suggested that we convert our schools into neighborhood recreation centers. Specifically, he is asking all communities to keep open their school sports facilities—the gymnasiums, swimming pools, tennis courts, tracks and playing fields — this summer.

Mr. Humphrey's request makes excellent sense. America has nearly $100 billion invested in its schools, yet most communities operate them at capacity only eight hours a day, 180 days a year.

Communities which already employ the approach recommended by the Vice President report that it costs only a few dollars per capita to cover the cost of staff, equipment, maintenance and other operating expenses. That's cheap compared to the cost of duplicating the trained leadership and extensive facilities which our schools employ only part-time.**—V. L. Nicholson, President's Council on Physical Fitness and Sports.**

Editorial Notes . . .

The Institutional Life Insurance Company of Indianapolis, which last year announced that it would issue life insurance to epileptics, now announces that it will sell its 20-Pay Endowment at 65 policy to retarded persons. Conditions of the policy are described as extremely liberal and the rates are the same as for the non-retarded.

As important as fire safety is everywhere, it is doubly important in a hospital. The Fire Safety Advisory Committee of the Joint Commission on Accreditation has

adopted as its basic standard the Safety Code of the National Fire Protection Association. The Joint Commission is emphasizing factors such as remodeling and interior changes, improper storage of flammables and use of unsafe materials as interior finishes as the chief concern. Since flash fires in ceilings due to flammable paints is one of a hospital's special hazards, the commission is recommending the use of noncombustible paints for all interior work.

The AMA Committee on Blood is publicizing the results of a controlled study of whole, pooled human plasma and a statement by the Plasma Committee of the National Research Council. It has been found that the effect of irradiating pooled plasma and storing it for months at 30-32°C. for the purpose of eliminating the hepatitis virus has been greatly exaggerated. The committee recommends the use of single donor plasma and serum albumin. It feels that the use of pooled plasma carries too high a risk except in the most compelling circumstances.

American tourists abroad may be assured of English-speaking, well trained physicians who will respond for moderate fees by referring to the "International Association for Medical Assistance to Travelers" (IAMAT). Twenty-four-hour service is offered in major cities in Europe, Asia, Africa and South America. Membership cards and directories are available without charge from IAMAT offices at 745 Fifth Ave., Squibb Bldg., New York City. IAMAT does not charge fees to its member physicians nor to travelers; it is supported solely by voluntary donations.

Erroneous testimony before the Senate Commerce Committee to the effect that Negro patients are given bigger doses of radiation than white persons prompted the following statement by the American College of Radiology: "There is no record that the American College of Radiology or any other national medical or scientific society has ever advised physicians to alter the energy settings of x-ray machines because of the race of the patient. We have not been able to find any valid scientific studies which would indicate any basis for increasing or decreasing the x-ray energy used, simply because the patient happens to be Negroid, oriental, American Indian or Caucasian."

Records of the National Intern and Resident Matching Program (NIRMP) indicate that between 1958 and 1968 the number of interns matched to major teaching hospitals increased on a percentage basis from 47.5 to 58.7. During the same period the percentage attracted to nonaffiliated hospitals decreased from 33 to 24.4. For the same 10-year period, the percentage of interns entering the program who were matched to an internship was remarkably constant—between 96% and 97%. Each year only approximately 55% of the approved internships are filled; the total participants have increased from around 7,000 to 8,306, but the approved internships have also increased from around 12,000 to 14,566.

Physical Education Professor A. H. Ismail of Purdue believes that there is a relationship between hearing sensitivity and the degree of physical fitness which is linked to health of the heart and blood vessels. The level of serum cholesterol is the key. Ismail is conducting a physical fitness program with physical and chemical tests before and after the program to determine the effect on hearing loss.

Fifteen insurance companies handle Medicare Part B benefits for all or part of 27 states and the Virgin Islands, which territory contains 40% of the nation's Part B recipients. They paid out more than $133 million in Part B benefits in the first quarter of 1968, an increase of 47% over the same period of 1967.

Improving the psychological and emotional environment of a hospital by improving its lighting is the aim of a young lighting consultant and designer who is now working on lighting for the Children's Hospital in Philadelphia. David Mintz observes that the operating room is the only segment of the hospital which is assured of critical attention to lighting problems. He thinks patients' rooms, corridors, lobbies, waiting rooms, lounges and, indeed, all the rest of the hospital could be better lighted.

The Army Medical Service Corps celebrated its 51st anniversary in May. Formed in 1917, and originally designated the Sanitary Corps, the organization now consists of over 5,700 officers trained to assist in a multitude of tasks in the Medical Department to free physicians for full-time attention to the sick and wounded. It now provides most of the Army's medical service functions in medical command, staff work, medical supply, pharmacy, training, personnel management and sanitary engineering.

Contraceptive drugs for men are a possibility for the future. Dr. Dolores Patanelli of the Merck Institute for Therapeutic Research reported recently that control of male fertility had been achieved in laboratory animals. Undesirable effects prevent their use in man, but other compounds are being sought. Both hormonal and non-hormonal drugs, each of which achieve contraception in a different manner, are being tested. ◄

President's Page

Dear Doctor:

Never in my life have I been more serious. Never have I been more sincere than at this time when I ask each of you, who may read this page, these questions.

What kind of a country do you want for yourself, your children and their children? What kind of a future do you envision for those of us who practice the healing arts? Will those of us of the present generation be guided by the ideals and sacrifices of our forebears who founded this greatest of all countries and pass on to our progeny the unquenchable desire and determination to perpetuate for all times the great principles and truths enunciated in our Declaration of Independence, our Constitution and our Bill of Rights? Will those of us who hold the degree of Doctor of Medicine be faithful to the marvelous heritage handed down to us by the great teachers of our profession?

Truly the world becomes more complex, and the problems we face as citizens and doctors become more complicated with the passing of each day.

The most important period of the year approaches rapidly. To each of us as citizens and Hoosier doctors, the national elections and our annual convention in October are momentous occasions. Every Indiana doctor should know that to the best of my knowledge, no more democratic organization exists than the ISMA. The annual meetings of the House of Delegates decide, absolutely, the policy under which we must operate.

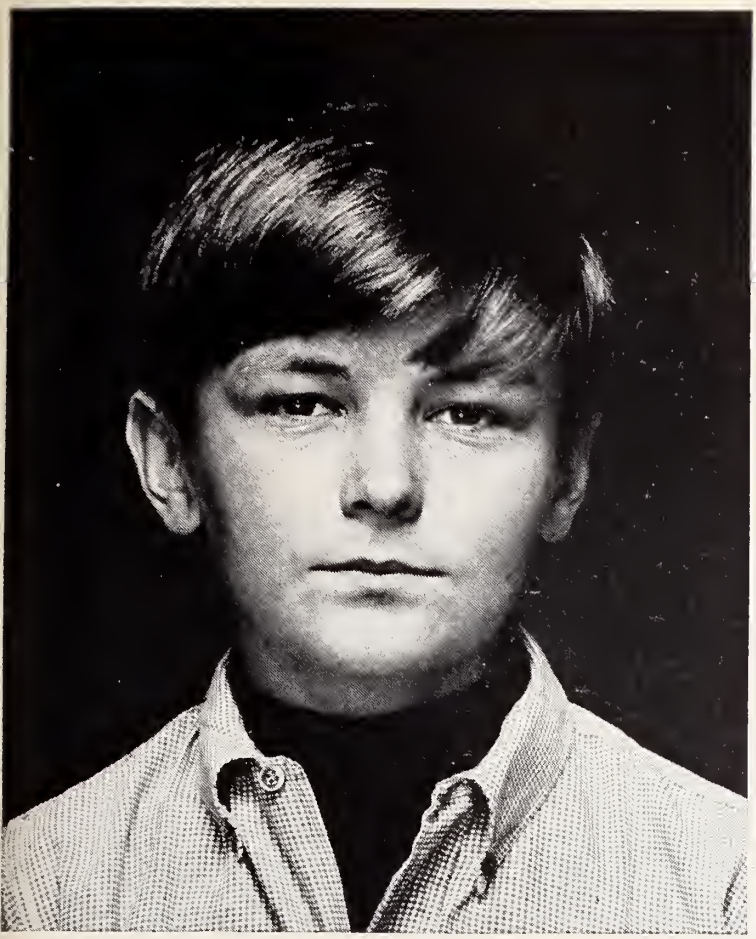
Every physician in the state has access to and may exert influence on one or more delegates to this body. Every physician in the state has the right and the privilege of appearing before and offering testimony on any and every report or resolution considered by any reference committee.

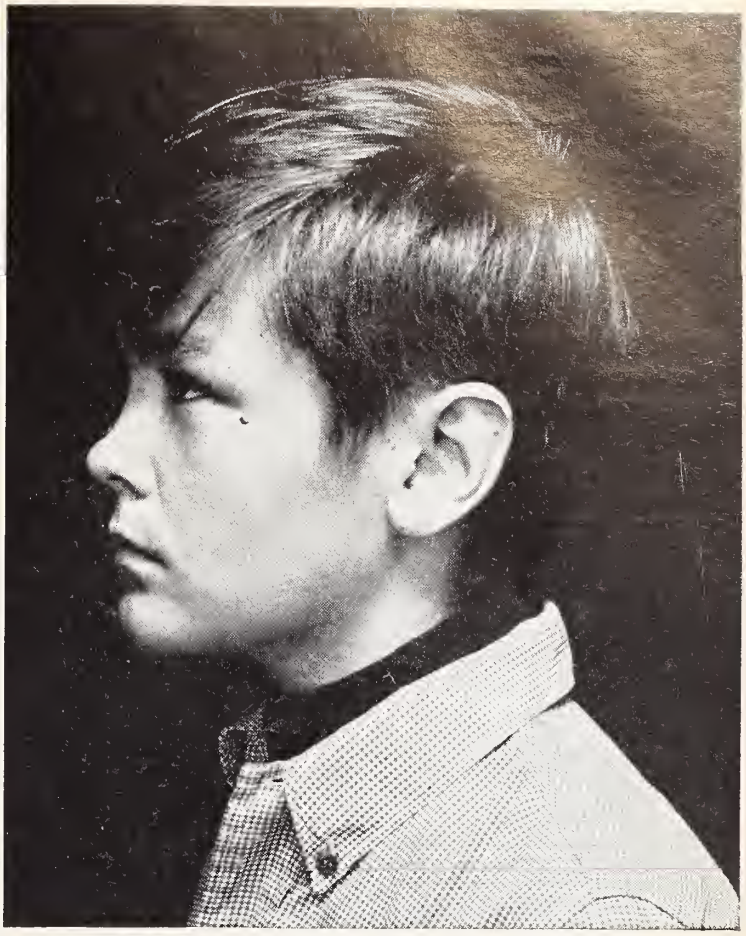
What are your views and opinions on the amalgamation of medicine and osteopathy, the liberalization of abortion laws, Medicare and Medicaid, comprehensive health planning, emergency care, the highway traffic toll and drunken driving. Do we need a new medical school in Indiana? If so, where? How can we better support our present medical school?

How can your county, district, and state medical societies be made more valuable to you and your community? How can those of us in positions of leadership be of more service to each of you? How can we communicate with each other better? How can we stimulate more interest in our association and its subdivisions? There is still time to introduce resolutions.

The greatest personal favor you can render to your president is to ask your friends to read this message, to give constructive consideration to any and all problems facing us and then to act in accordance with your convictions.

G. O. Larson M.D.





How to turn a 14-year-old boy into a hardened criminal.

Just forget your keys in your car one day.

Tempt some fourteen-year-old boy into going for a joyride.

Oh, he could be a good kid — just weak.

And taking your car might be the first time he's ever broken the law.

But the minute he hops behind that wheel and turns the key, his life may be ruined.

He'll drive around for a few hours, endangering the life of every man, woman and child who crosses his path.

He might be caught the very first time he takes a car. Or if he's not caught by the police he'll leave your car somewhere and decide to do it again, and again, until the day he does get caught.

Teen-agers steal more than 1,000 cars every day.

The U. S. Department of Justice and your state and local law-enforcement agencies are concerned.

They know that taking a car for a joyride is just the first step.

Our prisons are filled with men who started out this way. They went on to become thieves, muggers, and even killers.

You can do something to help solve this terrible problem.

Whenever you get out of your car, even for a second, take your keys. Lock your car.

Every time you do this you may keep a good boy from going bad.

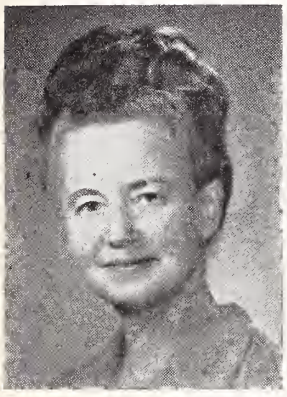
ADVERTISING COUNCIL

Don't help a good boy go bad. Lock your car. Take your keys.

The Woman's Auxiliary

REPORTS TO ISMA

A chief object of our auxiliary as stated in the Bylaws, is "to assist the ISMA in its program for the advancement of medicine and public health." Our programs and projects set up to implement this goal continue from year to year, up-dated, improved by past experience, given fresh impetus by the participation of new officers and chairmen with new ideas. We continually strive "to forge a system in which unshackled medicine can perform the new wonders of which it is capable."



This was the challenge presented the Woman's Auxiliary to the AMA in San Francisco in June by Philip Lesly, president of his own public relations firm, when he addressed the annual meeting. I quote freely from his remarks on "How Can We Prevent Being Defeated by Success?":

"Physicians' wives and their organization must use initiative for the type of system that will meet the needs of the public and of the doctors . . . rather than merely reacting to accusations, proposals and schemes propounded by others. What are some of the factors in the health-care picture that you and your husbands need to get across to America? First, much of America's health problem arises from the patient's own neglect. . . . Second, health care today is a system with *many* elements, not just the physician with his black bag and a few nostrums. . . . Third, people tend to see 'health care' as meaning the medical profession, and that is interpreted as being the doctor. All factors are related, but because of the doctors' visibility, prestige and leading role, they are blamed for the problems of the medical schools in failing to enroll more students, of the hospitals for their soaring costs, of the drug manufacturers, the pharmacists, the nurses, the insurance companies, the superimposed government health centers and other factors over which they have little control.

"You must stress the separate responsibility of the physician. The health-care system must work better. Wives should take an active part in the auxiliary's programs, such as the "Package Programs" of public health education on such matters as careers in the health field; immunization; youth health and physical fitness; the blood program. These show that local private sectors can make progress against the stubborn and underlying problems of community health. Be sure the medical profession gets credit for the things you do. Recruit support from other wives and laymen. Press for improvements that will overcome criticism of the profession and help make the system work better. Become opinion leaders on behalf of a balanced, sound approach to advancement of health care. Explain, educate, answer questions . . . in your church . . . with your local press and broadcast media . . . in politics. Become active politically; join your PAC's and see that your husbands do so.

"It is difficult for busy doctors to keep up with the increasing complexities of the non-medical world. Be their eyes and ears. Women are stabilizing forces and powers for good when they assert themselves. Urge enforcement of the highest standards of ethics and practice that will justify medicine's claim to being best able to direct the health care of the American people. Your husbands have participated in one of the great eras of human advancement. They and you are now faced with maintaining this advancement and avoiding having our whole health-care program driven over an abyss. Your formidable talents and determination will leave their mark on the future."

The Indiana auxiliary has already been at work in many of these fields and we take pride in our accomplishments as we continue our efforts toward these goals this year. The auxiliary needs *your* wife and her talents. Encourage her to join us; to be an active participant in our program. Our task is challenging and rewarding.

Betty Kephart

Now . . . a new
alternate salicylate product
from Warren-Teed

Magan®
(magnesium salicylate, W-T)

magan®
an alternate salicylate

particularly offered for the management
of those chronic arthritic and rheumatic
patients with gastrointestinal intolerance
to aspirin and other salicylates

pain relief comparable to aspirin

Magan may provide effective salicylate therapy for a substantial number of your patients who cannot tolerate other salicylates because of gastrointestinal irritation.

Magnesium salicylate is recognized as a safe and effective alternate to aspirin. A controlled clinical study showed Magan to be not significantly different from aspirin as an analgesic in the treatment of arthritic patients.[1]

Reports from a private practice experience study indicate that Magan was tolerated by a high percentage of patients judged by their physicians to be unable to take aspirin or other salicylates due to gastrointestinal intolerance.[2]

1. Stern, S.B.: Med. Times, Oct. 1967
2. Reports on 1200 patients, data in files, Warren-Teed Pharmaceuticals, Inc. 1966

(See next page for prescribing informatic

A different salicylate structure—
with no coating, no buffering
and it is sodium free

magan®
(Magnesium Salicylate, W-T)

microphotograph of magnesium salicylate crystals

Composition: Each orange-colored compressed tablet contains 5 grains (approximately 325 mg.) of magnesium salicylate, W-T (salicylic acid equivalent 75%).

Actions, Indications, Uses: The analgesic, anti-inflammatory, and antipyretic effects of MAGAN are similar to those of aspirin and other salicylates. Accordingly, MAGAN is indicated for the treatment of rheumatoid arthritis, osteoarthritis, nonarticular rheumatism such as bursitis, painful-shoulder syndrome, tendosynovitis, fibrositis, and other musculoskeletal disorders. The drug is also useful for the symptomatic relief of pain, aches, and discomfort of headache, neuralgia, minor injuries, dysmenorrhea, common cold and other minor infections of the respiratory tract. MAGAN (Magnesium Salicylate) may be tolerated by some persons intolerant to aspirin by reason of gastrointestinal irritation.

Contraindications: Because of the danger of hypermagnesemia, MAGAN is contraindicated in cases involving advanced chronic renal insufficiency. MAGAN, as other salicylates, may counteract the effect of uricosuric agents, and should not be prescribed for patients on such drugs.

Warning: As with all salicylates, high dosages of MAGAN should be avoided entirely or administered with caution to patients with liver damage, preexisting hypoprothrombinemia, vitamin K deficiency, and before surgery.

Adverse Reactions and Precautions: The same precautions applicable to salicylate therapy in general should be followed in prescribing MAGAN. Appropriate precautions should be taken in prescribing MAGAN for persons known to be sensitive to salicylates. If reaction develops, drug should be discontinued. Dosages of anticoagulants should be reduced with the administration of high dosage levels of MAGAN. *Impaired Renal Function:* Appropriate precautions should be taken in administering MAGAN to patients with any impairment of renal function including discontinuing other drugs containing magnesium and monitoring serum magnesium levels particularly if dosage levels of MAGAN are high. *Salicylate Poisoning:* Symptoms of salicylism, resulting from high doses of MAGAN, can be expected to resemble closely in character and intensity those associated with aspirin poisoning. These range from dizziness, drowsiness and ringing in the ears to vertigo, convulsions, coma and hypokalemia. Salicylate poisoning can be treated by intravenous fluids with sodium bicarbonate or lactate and potassium supplementation. In very severe cases, hemodialysis may be necessary. Vitamin K, 5-20 mg. orally or slowly i.v., usually restores the prothrombin time to normal.

Dosage: Adults 1 or 2 tablets every 4 hours as required with a full glass of water. In arthritis and other rheumatic conditions, higher doses may be used at the discretion of the physician. The experience with MAGAN in children is limited. The drug should not be used, therefore, for patients below 12 years until indications for use and dosage have been established.

How Supplied: Bottles of 250 and 1000 tablets.

WARREN-TEED PHARMACEUTICALS INCORPORATED
COLUMBUS, OHIO 43215
SUBSIDIARY OF **ROHM AND HAAS COMPANY**

Errant currents from faulty electronic equipment are reported imperiling patients in certain cases.

The Tiny Flaws in Medical Design Can Kill*

RONALD GECHMAN
West Coast Editor

A seemingly harmless voltage of 20 millivolts can kill a hospital patient under certain conditions. Moreover such a current may be generated by poorly designed electronic equipment.

Add to that the fact that there are today no Federal, state or local standards to regulate the design, construction and electrical safety of equipment used in a hospital room or doctor's office, and the potential for continuing tragedy exists.

This is the picture painted by medical and engineering critics of some of today's electronic equipment. Deaths have, in fact, already resulted, they say. The cause may be attributed on the death certificate to "ventricular fibrillation" or some comparable medical term.

Two major flaws in equipment are turning up, according to the critics, as medical electronics, still in its infancy, reaches out toward growing markets:

- Faulty components in instrumentation and monitoring devices.
- Wiring systems that do not provide maximum protection for a patient.

Efforts to set safety design standards are being pressed by such professional groups as the Safety Committee of the Instrument Society of America, the Corresponding Committee of the IEEE and the Standards Committee of the Association for the Advancement of Medical Instrumentation. However, they report little headway toward achieving their goals. To fill the void, some manufacturers have begun to set their own standards. And in Congress a bill has been introduced in the House of Representatives to create a national commission that would study the quality controls and manufacturing procedures of, among others, companies that make medical instrumentation equipment.

Basic to the problem, the critics say, is that many hospitals lack adequate grounding systems for their electrical wiring. Except for their use in operating rooms, isolation transformers, designed to protect a patient from grounding accidents, are reported in scarce supply. Some hospitals do not use ground wires but rely on the conduit alone for grounding.

A leading critic, Dr. Paul Stanley, Professor of Aeronautics, Astronautics and Engineering Sciences at Purdue University, Lafayette, Ind., says that doctors are well aware that small electric currents applied to the body can be fatal, but that they are not fully aware that malfunctioning hospital instruments can produce these voltages. The malfunction may be no more than a leaky capacitor in the instrument's power supply, and it may go unnoticed for some time, Dr. Stanley says.

A number of studies indicate that ventricular fibrillation is responsible for the majority of deaths from electrical shock, he reports. In ventricular fibrillation various groups of the heart muscle fibers stop operating in rhythm; instead they operate independent of one another. The result is weak, sporadic heart action that produces death.

Accurate figures on deaths occurring from accidental shocks in hospitals are nearly impossible to obtain, Dr. Stanley concedes. However, instances of death or near-death are reported from time to time.

At one Midwest hospital, according to Dr. Stanley, 40 to 50 patients were shocked over a few months in 1965, owing to a design error in an electromechanical dye injector. He declines to identify the hospital publicly, but he says the machine has since been removed from the market. Parts of it were anodized before assembly, and while this effectively insulated the parts and caused a high resistance path to ground, the patients were grounded through other instruments. Since the patients were a better ground than the dye injector, current from the injector through the patients produced severe shock.

Similar cases were reported that same year by the University of Wisconsin. One patient died and six others were severely shocked by the same dye injector.

In Europe the leading British medical journal, *The Lancet*, reported two instances where patients were severely shocked by broken ground connections. Another case was reported last January in a news story from Yugoslavia telling

* Reprinted from *Electronic Design*, September 1, 1967.

of a patient's death from electrical shock caused by a defective electrocardiograph.

It is bad enough when a healthy person is subjected to such shocks, Dr. Stanley says, but the problem is drastically compounded when a hospital patient, especially one suffering from a heart problem, receives the shock from an electrical device attached to his body.

In an ordinary, nonmedical situation, the resistance of two electrodes placed on the skin can vary from 500 ohms to 5 kΩ, depending upon moisture, oils in the skin and the amount of dead skin under the electrodes. But needle electrodes inserted into the body of a patient often reduce the body resistance to zero.

"Under these circumstances, a current as low as 20 uA will probably cause fibrillation," according to Dr. Stanley. He adds that a voltage as low as 20 mV can be fatal and that a voltage of even 2 mV can be seriously harmful.

Assailing "poorly designed and shoddily built" equipment, Dr. Stanley says: "In some instances, circuits have been lifted directly from published articles on the design of medical instruments, without verifying the circuit's adequacy for the company's particular application."

One example of a design error in a heart-lung machine, he says, was one in which the manufacturer put the fuses for six critical motors inside the machine; it took 15 minutes to remove enough screws to reach the fuse box. The manufacturer subsequently relocated the fuses to a more convenient spot.

Other examples of poor equipment design cited by Dr. Stanley include these:

- Defibrillators that produced excessive shock energies.
- Equipment with chattering relays that produced high-voltage leakage currents.
- Pacemakers that were sensitive to pulses on the power line.

An instance where a cardiogram was being taken illustrates what can happen from faulty wiring, Dr. Stanley says. The technician received a severe shock every time she attempted to attach the leads to the patient. The problem was traced to a bed lamp frame that was shorted to its frayed ac line cord. The lamp was touching the bed frame and so was the patient's arm. Since the cardiogram was grounded through a three-prong plug and the lamp was not, the full ac line voltage, 117 volts, was shooting through both the patient and technician.

Isolation Transformers Needed

To prevent similar situations from arising, Dr. Stanley suggests that all supplies be connected through isolation transformers with a separate ground for each room. The transformer would prevent a shock from accidental grounding.

Dr. Jerome Silver, a former electrical engineer and now a surgeon at the Weiss Memorial Hospital in Chicago, echoes Dr. Stanley's concern over hospital safety. He was instrumental in forming rules for the hospital that require every electrical item to be equipped with a three-prong plug, and the plug must be installed by the hospital staff.

In addition Dr. Stanley suggests that all hospitals employ an engineer, who will be responsible for all their electrical systems and equipment. The engineer's duties, he says, should include:

- Inspecting all plugs on a periodic basis, to make sure they are in proper working order.
- Replacing tubes in the electronic equipment at recommended intervals, to minimize equipment failure at critical times.
- Checking instruments at recommended intervals, to ensure that they are properly calibrated.

One complaint hospitals have is that some manufacturers are unwilling to supply sufficient information for independent repair of defective instruments, because they receive extra revenue from the repair of their own equipment. When defective equipment is too large to be sent back to the company for repair, the hospital typically must pay $150 a day for the company to send out an engineer to repair it.

Dr. Leon Riebman, president of American Electronics Laboratories of Colmar, Pa., notes a problem that manufacturers face in designing medical equipment. "Many doctors and hospitals," he says, "cannot agree among themselves on an acceptable design approach for a new medical instrument. This disagreement has caused so much confusion among the companies trying to develop new instruments that the companies are not apt to spend their funds for new instrument designs which could be used more profitably in other areas."

David Kilpatrick, head of American Electronic's Medical Engineering Div., says that because of the lack of general standards, the company has developed its own for medical equipment.

Alarm Checks Grounds

Among the company's rules for its designers are these:

- All equipment must have three-wire, color-coded cords and plugs.
- The hot side of the line must be fused no more than 200% of design current.
- Power switches must be installed on the hot side of the line or both sides, but never on the neutral side only.
- Modular combination of subsystems on a single patient must be made through a junction box that contains ground current monitoring, alarm and disconnect circuitry.

For wiring in hospital rooms, Dr. Stanley recommends that every electrical outlet have a No. 10 or No. 8 ground wire going to a ground bus. Each bus should handle

a group of rooms and have a No. 0 wire going to a separate earth ground, he says. He also recommends that isolation transformers be used throughout the hospital.

Another recommendation of his is the use of a device to detect and sound an alarm automatically if an open ground connection occurs in a piece of operating equipment. The National Electric Code requires that such an alarm be installed in operating rooms, but it is not required elsewhere in the hospital.

Under the bill introduced in the House of Representatives last February by Rep. Ed Reinecke (R-Calif.) a National Devices Standards Commission would be set up. The commission would not only study the instrumentation equipment used in hospitals and doctors' offices. it would also determine what Federal regulation of the equipment was needed to ensure that it meets minimum performance standards. The regulations would come under the jurisdiction of the Food and Drug Administration. Rep. Reinecke's bill, H.R. 6165, is under study.

At present the danger of shock from electrical equipment attached to a person is not limited to hospitals and doctor's offices. It could extend to test equipment used in schools. One example brought to light recently involved a three-year study completed by the University of North Carolina for the Public Health Service.

The study was designed primarily to obtain information on the calibration and general operating condition of audiometers. It uncovered disturbing information about the safety of the machines. More than 25% of them were found dangerous to operate. Two of the 100 machines tested had a potential of 117 volts on the outside case when plugged into the ac line, and 25 more units tested had enough potential on the case to produce a shock when touched. In addition not a single machine tested met the study's calibration specification.

Dr. Joseph Stewart, audiology consultant for the study, says that an audiometer that is out of calibration can cause serious errors in large-scale screening programs.

"It can, for example, miss the child with a potentially dangerous infection of the middle ear."

The audiometers tested were obtained from health departments, public schools, physicians and hospitals, military and industrial installations, the Veteran's Administration and hearing-aid dealers.

The study traced the inaccuracy of most test instruments to owners or operators who apparently had been unaware of the need for periodic calibration. Nearly half of the instruments had not been calibrated from the day they were purchased.

When technicians removed the back of one audiometer being used by a physician, they found a rat's nest inside, constructed in part from bits of the instrument's wiring and insulation materials.

Most manufacturers, the study found, were not utilizing the latest electronic technics, such as solid-state construction. Kilpatrick says that some audiometers on the market today are at least 30 years behind modern technology.

One of the audiometers tested was a brand new unit. When it was removed from its packing case, it was found to be so badly out of calibration that it had to be torn apart and completely rebuilt. ◄

INDIANA MEDICAL BUREAU
816 Hume Mansur Bldg.
634-5804

A Licensed Employment Agency
Specializing in Medical Personnel

Our 17th Year Of Service

GLEANED FROM THE BRITISH MEDICAL JOURNAL

JACK W. HICKMAN, M.D.
Indianapolis

Second Heart Sound Splits Under Fluid Overload—Uremic or Otherwise

An article from London indicates that an abnormally split second heart sound may be a frequent physical finding in patients with advanced renal failure.[1] All eight patients who were observed by the author had widely split second heart sounds noted on auscultation, and confirmed by phonocardiographic determination. None of the patients had atrial septal defects or other congenital heart lesions that might cause such a finding. In seven of the eight patients, however, the splitting disappeared after diuresis was induced. The author concludes his findings by stating that this physical finding appears to be a useful sign of fluid overload in the uremic patient. Actually this observation is very likely correct but only in the sense that it is true for all clinical situations in which fluid overload occurs with resultant cardiac decompensation. It is doubtful that it bears any particularly distinctive relationship to fluid overload from a renal basis as opposed to other underlying etiologies.

Glucagon Moderates Blood Glucose Tide

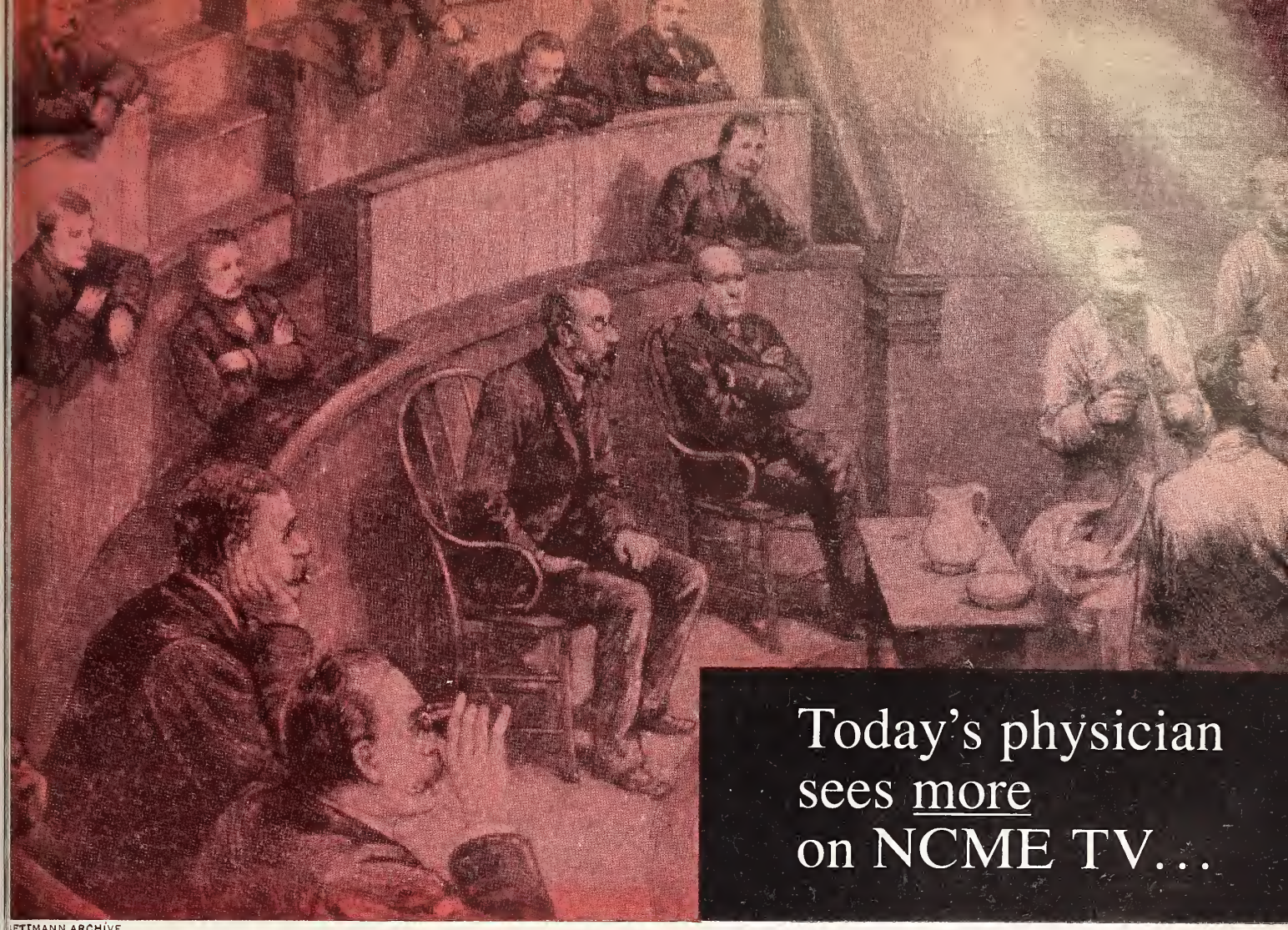
Glucagon has been available to clinicians for some years now and has been quite useful as a form of therapy for hypoglycemia. Renewed interest in its actions has occurred recently and it has been particularly significant that early studies have shown it to have a beneficial effect in improving cardiac efficiency under certain circumstances. Turner et al.[2] studied the effects of glucagon when it was administered intravenously along with a standard intravenous glucose tolerance test. These studies were performed on eight healthy subjects who had previously had an intravenous glucose tolerance test done without glucagon. The authors found a higher plasma insulin level occurred when the glucagon was given, but that the blood sugar levels were also higher during the early stages of the test. Their results mitigate against the proposal that intestinal glucagon is, in fact, the beta cell stimulant that triggers insulin release, as others have suggested.

Crowded Living Neither Comfortable Nor Healthy

As concern in society is expressed about substandard housing, studies such as the one by Fanning[3] should receive increased notice. The author, who, interestingly enough is a Wing Commander in the R.A.F., undertook to examine the health standards of people in different living conditions. His data were reported from studies of the families of members of military service personnel stationed in Germany. He reports that the morbidity of families living in "flats" was 57% greater than those living in houses. The greatest differences were found in the incidence of respiratory infections in young women and children, and of psychoneurotic disorders in women. With our present propensity to build multi-level apartment dwellings in an attempt to replace substandard housing, perhaps the planners should not disregard findings such as these.

REFERENCES

1. Gibson, D. G.: Abnormal Splitting of the Second Heart Sound in Renal Failure, *Brit. Med. J.* 4:141-144, No. 5572.
2. Turner, D. A., et al.: Effect of Glucagon on Intravenous Glucose Tolerance, *Brit. Med. J.* 4:145-146, No. 5572.
3. Fanning, D. M.: Families in Flats, *Brit. Med. J.* 4:382-386, No. 5576. ◄



Today's physician sees more on NCME TV...

ETTMANN ARCHIVE

The first nationwide medical television service, NCME—The Network for Continuing Medical Education—brings you visually the important achievements of leading medical authorities. By means of closed-circuit television, this independent network provides your hospital or medical school with a complete videotape service that helps shorten the gap between new medical knowledge and its availability for clinical or teaching purposes.

NCME The Network for Continuing Medical Education

NCME TV Offers These Practical Benefits:

☐ Every two weeks a new 60-minute videotape dealing with three separate medical subjects is sent to participating institutions.

☐ Content and format of NCME telecasts fulfill criteria for postgraduate medical education, permitting American Academy of General Practice course credits under specified conditions.

☐ To help your institution make effective use of closed-circuit television, NCME offers a wide range of services and utilization aids, including: Technical consultation in setting up a closed-circuit system; advance program information on the contents of each telecast; display units to help publicize programs; expense-paid seminars to improve utilization of medical television.

☐ NCME programs are brief and may be shown as often as desired; you can view the telecasts at times that are most convenient, without disrupting your normal schedule.

☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to NCME, 342 Madison Avenue New York, N.Y. 10017

Report on Actions of the House of Delegates

American Medical Association
117th Annual Convention
June 16-20, 1968
San Francisco, California

K. W. BUSH
Administrative Assistant, ISMA

INDIANA State Medical Association officials and delegates to the 117th annual convention of the American Medical Association considered, debated and voted on issues presented to the House of Delegates of the AMA June 16 through June 20 in San Francisco.

Decisions by this policy-making body of the association involved careful consideration and scrutiny of 85 resolutions introduced by the various state delegations, 39 reports of the AMA Board of Trustees and 19 Council and committee reports.

In preparation for the AMA meeting, the Council of the Indiana State Medical Association met in a day-long special session on Sunday, June 9, to consider the advance Board of Trustees' reports and 48 resolutions with the objective of advising ISMA delegates of the official position of ISMA on the reports and resolutions. In many instances, because of the nature of some resolutions, the Indiana delegation was directed to use their best judgment on their votes in the house. The Council recommended opposition to eight reports and resolutions and amendments to five others.

Dr. Guy A. Owsley of Hartford City was elected chairman of the delegates. Other delegates in attendance at the meeting included Drs. Don E. Wood and Dwight W. Schuster, both of Indianapolis; Eugene F. Senseny, Fort Wayne and Frank H. Green, Rushville.

Alternate delegates in attendance included Drs. Robert M. Brown, Marion; Kenneth O. Neumann, Lafayette, and Maurice E. Glock, Fort Wayne. Acting as alternates, in the absence of Dr. Jack Shields of Brownstown, and Dr. Harold Ochsner of Indianapolis, were Dr. Lowell Steen, Hammond, chairman of the ISMA Council and Dr. P. J. V. Corcoran, ISMA president-elect.

To keep abreast of current daily changes in the business of the house, Dr. G. O. Larson, LaPorte, ISMA president, called a June 15 meeting and three breakfast meetings of officials and delegates to hear reports, decide on reference committee assignments and other actions.

Meeting with this group to assist were Drs. Ralph V. Everly, Indianapolis, chairman, ISMA Executive Committee; Burton E. Kintner, Elkhart, member, Executive Committee; Lester H. Hoyt, Indianapolis, treasurer of the association; M. O. Scamahorn, Pittsboro, assistant treasurer; Lall G. Montgomery, Muncie, delegate from the AMA Section on Pathology and Physiology; Sprague H. Gardiner, Indianapolis, alternate delegate from the AMA Section on Obstetrics and Gynecology, and Lester D. Bibler, Indianapolis, AMA Board of Trustees.

Elections

Despite an all-out effort by the Indiana delegation to retain Dr. Lester Bibler as a member of the AMA Board of Trustees for his final term, Dr. Bibler lost to Dr. Raymond T. Holden of Washington, D.C. by a narrow margin. The only incumbent retained in four elections for the board was Dr. L. D. Simenstad of Wisconsin. The two other trustees elected were Dr. John M. Chenault, Alabama and Dr. John R. Kernodle, North Carolina.

In other action by the House of Delegates, Dr. Gerald D. Dorman of New York was named president-elect of AMA and Dr. Dwight L. Wilbur of San Francisco assumed the office of president for 1968-1969. Dr. Carl A. Lincke, Ohio, was elected vice-president; Dr. Walter C. Bornemeier, Illinois, was re-elected to the office of speaker of the house and Dr. Russell B. Roth was returned to his post as vice-speaker.

Dr. Francis Land, former Fort Wayne physician, was re-elected to the Council on Medical Education.

Also of interest to the Indiana delegation was Resolution 47, introduced by Indiana in Houston in 1967, and subsequently referred to the Board of Trustees for study.

The resolution asked that the appropriate department of AMA prepare, cause to have introduced and work for the passage of federal legislation to declare doctors exempt from any federal requirements of an interstate commerce nature.

In Report M of the Board of Trustees which resulted from the board's investigation it was pointed out that "The legal issue actually involved is whether employees in a physician's office who are not licensed physicians are entitled to the benefits of the Fair Labor Standards Act, which establishes minimum wage, overtime pay, record keeping and other standards for most of the employees in the company. . . ." Report M also stated that "...the Legal Research Department is convinced that employees in the physicians' office are not covered by the FLSA."

The Law Division of AMA and the board agreed, however, that the most appropriate action of Resolu-

tion 47 is to 1) furnish general information on the question of FLSA coverage; 2) urge that physicians voluntarily adopt minimum wage, overtime pay and record keeping practices equal to those established by FLSA; and 3) recommend that any physician confronted by a claim that his employees are covered by the FLSA consult his attorney for the purpose of resisting that claim. The ISMA Council, at its June 9 meeting had already moved to support this report.

Other Actions

In pinpointing some of the other actions of the house from the immense volume of business which was undertaken, the delegates:

—Were advised that a full day working conference on comprehensive health planning has been scheduled for November 30, 1968 in Miami Beach immediately before the 1968 Clinical Convention.

—And that a handbook on comprehensive health planning is nearing completion and will include some "tactical" suggestions to medical associations for effective participation in planning.

—Referred resolution 74 on Health Care Financing to the Board of Trustees with the recommendation that the AMA approve in principle a graduated income tax credit for health insurance premiums paid out for adequate medical and hospital services coverage.

—Strongly disapproved of the provision of funds by the Federal Government to subsidize any one form of medical practice.

—Resolved that the AMA request the Secretary of Health, Education and Welfare to continue to solicit the advice and counsel of those practicing physicians designated by their medical associations at the local, state and national level, in formulating future plans and programs and in modifying existing programs, in order to provide the best quality health care for the people of the United States.

—Asked the AMA to arrange for a new draft of standards of the Joint Commission on Accreditation and circulate the draft to state medical associations for comment before final adaptation.

—Resolved that the House of Delegates continue to urge that adequate representation of the medical staff on the voting membership of the hospital's governing body is the most effective mechanism for assuring a working communication provided that physicians serving on the governing board be nominated by the medical staff of the hospital.

—Adopted a portion of a lengthy report by the Board of Trustees on infant mortality and urged state and component societies to evaluate existing maternal and child care resources and take leadership in the expansion and development of programs for delivering services in locations found to be deficient. (ISMA Council has directed that this report be made to the House of Delegates of ISMA in October).

—Cited erroneous information contained in "A Report on Laboratory Performance and Methods for Improvement" published by the Department of Health, Education and Welfare in June, 1967 and requested the AMA to advise HEW that errors were made in the report and published in *The Congressional Record*, and that the secretary of HEW be asked to respond.

—Urged the AMA to continue its efforts to safeguard and inform the medical profession and the public with respect to the treatment of obesity.

—Reaffirmed the previous policy of the AMA to eliminate recertification in P. L. 89-97.

—Approved a resolution that "The bylaws of the AMA be amended to provide that in addition to receiving 'appeals filed by applicants who allege that they, because of color, creed, race, religion or ethnic origin, have been unfairly denied membership in a component and/or constituent association,' determining facts and reporting its findings to the House of Delegates, the Judicial Council shall, if it determines the allegations are indeed true, admonish, censure or, in the event of repeated violations, recommend to the House of Delegates that the state association involved be declared to be no longer a constituent association of the American Medical Association."

—In the area of reducing costs to patients, adopted a resolution that "the AMA endorse the principle of voluntary health insurance coverage for outpatient x-ray and laboratory services acceptable to the hospital and its medical staff wherever performed prior to a scheduled hospital admission;" and adopted another resolution that "all insurance companies and fiscal intermediaries" adopt and authorize the use of standard forms in conjunction with a single hospital admission to save physicians' time and expense.

—With respect to relationships and negotiations between the AMA and the osteopaths, accepted for information a Board of Trustees report which stated "In the absence of cooperative leadership on the part of the

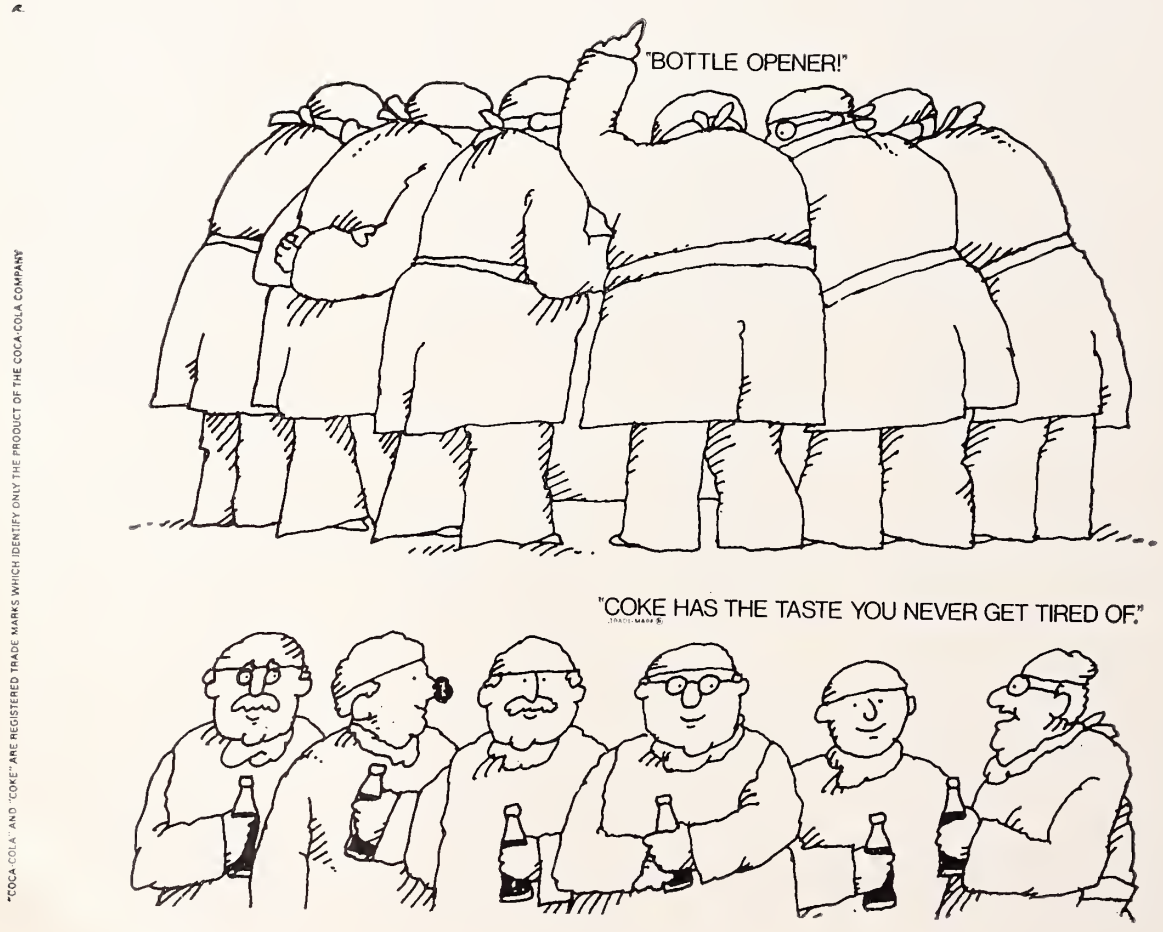
practicing osteopaths and osteopathic educators, accomplishments by the AMA are rendered difficult. Such leadership was forthcoming in California, and is now needed elsewhere. When this osteopathic leadership is developed, the AMA stands ready to cooperate to its utmost."

—Voted to "participate in a program of planning and action with other organizations concerned with architectural barriers to the handicapped" and requested state and county medical societies to encourage their members to become active in helping to alleviate such barriers.

—Referred to the AMA's policy on chiropractic and urged state and local medical societies "to formally adopt the AMA Policy Statement on Chiropractic, or a somewhat similar expression" and "to alert the general public to the health hazard posed by the cult of chiropractic."

—Adopted a Judicial Council report on "Ethical Guidelines for Organ Transplantation." One of several important guidelines was, "When a vital, single organ is to be transplanted, the death of the donor shall have been determined by at least one physician other than the recipient's physician. Death shall be determined by the clinical judgment of the physician. In making this determination, the ethical physician will use all available, currently accepted scientific tests."

—Referred to the Board of Trustees a resolution to establish a joint commission on accreditation of nursing schools, with participation by the AMA, American Hospital Association, American Nurses Association and National League for Nursing. ◄



Medical Panorama

Thanatology Resurrected

A. W. CAVINS, M.D.
Terre Haute

TODAY we see much in print about the technical definition, or the determination of death. This has swelled up in a great chorus since the world-wide publicity anent the first human heart transplant, and daily it seems to gather momentum. After the first wonderment came the query: what of the poor donor? And what indeed! We find that when the "moment of truth" arrives we are not *dead* sure when a man *is* dead, to everyone's satisfaction.

But before the spectacular of organ transplant, a quieter controversy had been in progress ever since it became possible to prolong life in man, even though in a vegetative form of passive existence, almost indefinitely. After the marvel of it had worn off, the question arose: is this ethical? is it right?

In line with this is a June 10 *AMA News* story from the Manitoba Medical Association's recent annual meeting at Winnipeg. The Manitoba doctors have recommended to the Canadian Medical Association that physicians be allowed to deny care to "patients who are not only beyond hope of cure but who are unable to die in dignity because of continued therapy." Concurrently, the Canadian Medical Association has plans for a committee to define life and death. Who would have thought, when I was a boy, that it would come to this?

The fact is, someone did think of it and published in *The Journal of the American Medical Association*, April 27, 1912, an article entitled "Thanatology. A Questionaire and a Plea for a Neglected Study." The author was Roswell Park, M.D., LL.D. (Yale), for whom the Roswell Park Memorial Institute, Buffalo, N.Y., is named. This is a short but penetrating essay upon "the nature and causes of death", well worth being reprinted in its entirety. A few quotes may entice you to look up the original of 56 years ago:

"What is death? When does it actually occur? How can it occur when the majority of cells in the previously living organism live on for hours or for days, or, under certain favoring circumstances, retain potentialities of life for indefinite periods? . . . . Does life inhere in any particular cell? In the leukocytes? In the neurons? Both are capable of stimulated activity long after the death of their host. In fact, by suitable electric stimulation, nearly all the phenomena of life may be reproduced after death, save consciousness and mentality alone. . . .

"The life of a cell is then necessarily quite distinct from the life of its host, nor can the latter be composed simply of the numerical total lives of its components. . . .Certainly when a patient dies of progressive gangrene he has outlived, perhaps, a large proportion of his millions of competent cells. Viewed properly, what a strange spectacle is here presented! Perhaps twenty percent of his cells actually dead, the rest bathed in more or less poisonous media, still their host endures yet a little while. . . . .About which of the poisoned cells does the flame of life still flicker?"

But wait! Do you think the problem of ethics in organ transplantation did not exist before *this* generation? To quote further: . . . "That flowers and fruit of one kind may be made to grow on a tree of a very different kind excites but a small amount of the astonishment it deserves, mainly because it is now a common occurrence, though properly regarded it might seem a miracle.

"Differing only in minor respects is, for example, the removal of thyroid tissue from one human being and its implantation into another, with functional success. . . .If this tissue were taken from a fresh corpse it would be by most people regarded as dead tissue. If so, does the dead come to life? . . . . Let a healthy young woman meet accidental and instantaneous death. It would be possible to use no inconsiderable portion of her body for grafting or other justifiable surgical procedures." Then follows a long list of such procedures, known at that time and ending with the postulation of kidney transplant. He goes on:

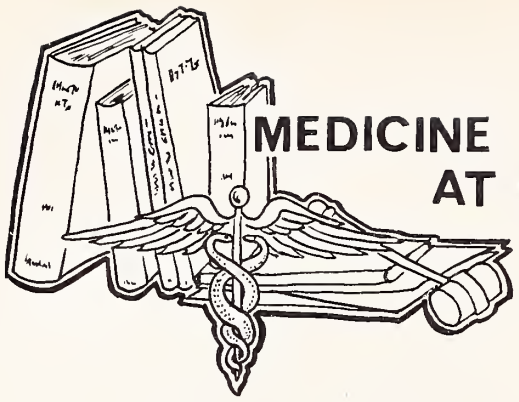
"This is, after all, not a fantastic dream, nor such an extreme picture as would at first appear, since every organ or tissue above-mentioned—and more—has been used as indicated, and with success.

"But imagine the dead body affording viable products, even indirectly life itself, to (possibly) so many others! Does this complicate the study of death? . . . .

"There is something more than mere transcendentalism in the Science of Thanatology; it has a plausible medicolegal and pragmatic import. Right glad should I be if I might arouse a deserved interest in it."

Please note that at least one physician in 1912 was already concerned with the "medicolegal and pragmatic import" of transplantation procedures.

221 S. Sixth St.
Terre Haute 47801



MEDICINE AT LAW

Physician's License Revoked for Professional Incompetence— The Supreme Court of Kansas has upheld an order of the state's Board of Healing Arts revoking a physican's license for "extreme incompetency" in the management of cases under his care. A trial court has reversed the Board's order because the statute authorizing revocation of a physician's license for unprofessional conduct did not list incompetency as one of the specified acts amounting to unprofessional conduct. In reinstating the revocation order, the Kansas Supreme Court decided that the Board had not exceeded its authority and had not unlawfully created a new ground for revocation.

New Trial in Fracture Suit— A verdict was improperly directed for a physician in a suit by a patient who suffered a Volkmann's contracture following reduction of his fractured arm, a Texas appellate court ruled. The patient presented sufficient evidence to make a case for the jury as to whether there was any negligence on the physician's part that was the cause of the injury.

The patient sustained a supracondylar fracture of his left arm at a point just above the elbow. When he was brought to the physician, he had movement in the fingers and forearm and had good radial pulse. After making x-rays, the physician reduced the fracture, put some cotton down in the bend of the elbow joint, wrapped the arm in bandages, and taped the forearm to the upper arm so as to hold the elbow at about a 60 degree semiflexed position. The patient's arm was swollen and discolored the next day. The physician examined the arm and said that the bandage was not too tight. The following day the patient had a high fever, and blisters had appeared on his arm. The physician hospitalized him. Upon examination, the physician found that there was some constriction of circulation of the soft tissues of the forearm and the arm had no radial pulse. He concluded that the patient had an infection, and he administered antibiotics. Several days later, when the fever and infection had cleared, he referred the patient to an orthopedist.

The following was undisputed: the Volkmann's contracture was caused by starvation of the muscles and nerves in the arm for lack of blood supply; the patient's arm had a good radial pulse after the injury, which indicated that the injury had not impaired the blood vessel; a tight bandage around the arm is one of the recognized causes of the loss of radial pulse and of circulation. An expert medical witness for the patient testified that the physician, in placing cotton in the bend of the elbow and drawing the arm up in a flexed position with tight bandages, did not act in accordance with accepted standards of practice. He also stated the opinion that such method of treatment caused the Volkmann's contracture. This evidence was sufficient to raise issues for the jury as to negligence and proximate cause.

The case should have been submitted to the jury even though the patient's expert witness also testified that the contracture could have developed pathologically by the formation of a blood clot. The patient was not required to prove causation by direct and positive evidence which excluded every other reasonable hypothesis. There was evidence showing the reasonable probability that the physician's negligence was the proximate cause of the injury. That was sufficient to raise an issue for the jury—*Rose v. Friddell,* 423 S.W.2d 658 (Tex., Dec. 28, 1967; rehearing denied, Feb. 8, 1968).

Original Tortfeasor Joined in Malpractice Suit—A physician sued for the wrongful death of an injured patient was permitted to sue the person allegedly responsible for the patient's injuries. In the suit against the physician it was charged that the patient's death was caused by allegedly negligent treatment of injuries sustained in an automobile accident. The physician's third-party complaint was against the driver whose negligence caused the accident. Under the Federal Rules of Civil Procedure, the physician was required to show that the driver "may" be liable to him. The court said that it could envision situations which, if proved, could establish the physician's right to contribution against the driver. It would therefore be premature to dismiss the third-party complaint before the trial.

A hospital and several other physicians who were also named in the wrongful death suit sought to achieve the same result by filing "cross-complaints" against the driver. Such a pleading was not the

proper procedure under the Federal Rules in a situation such as this. Their "cross-complaints" were dismissed without prejudice to their right to file third-party complaints against the driver.—*Murray v. Haverford Hospital Corp.*, 278 F. Supp. 5 (D.C., Pa., Jan. 11, 1968).

Hospital Anesthesiologist's Automobile Expenses—A physician specializing in anesthesiology and employed full time at a county hospital was not permitted to deduct the expenses of driving her automobile to and from the hospital. She worked a regular five-day week and, in addition, was on call for 24 hours every other weekday and for 48 hours every weekend. She had no outside medical practice. The Tax Court ruled that the automobile expenses were nondeductible personal commuting expenses.—*Sheldon v. Commissioner of Internal Revenue*, Docket No. 1816-67 (Tax Court, April 4, 1968).

Legal Fee for Defending Physician on Attempted Bribery Charge—A physician was not allowed to deduct, as a cost of doing business, a legal fee of $26,500 paid to an attorney for defending him on an attempted bribery charge. The charge arose after the physician had been sentenced and fined for income tax evasion and then attempted to bribe the judge to suspend the sentence. He was convicted and sentenced to prison on the attempted bribery charge. His license to practice medicine was revoked for tax evasion.

The Tax Court ruled that the legal fee was a nondeductible personal expense and could not be deducted either as an expense of doing business as a physician or as an expense of conserving income-producing property (his state license to practice medicine). The purpose of the attempted bribery, the court held, was not to obtain a reversal of his tax evasion conviction (which might have helped him to retain his medical license) but to evade the penalty for the conviction.—*Margoles v. Commissioner of Internal Revenue*, Docket No. 2241-66 (Tax Court, April 8, 1968).

Hospital's Insurer Liable in Sponge Case—A hospital's liability insurer was liable in a patient's suit for injuries resulting from the leaving of a sponge in her abdomen during a hysterectomy, a Louisiana appellate court ruled. The negligence of the hospital's nurses in counting the sponges was within the policy's coverage, and the protection of the doctrine of charitable immunity did not extend to the insurer.

The evidence established that the nurses made an incorrect count of the sponges used in the operation. No evidence was required to establish that such a miscounting constituted negligence.

This suit was brought against the physician who performed the operation, the hospital, and the hospital's insurer. The evidence supported the finding that the sponge was not left in the patient's body as the result of any negligence on the part of the physician. There was expert testimony that the physician was entitled to accept the nurses' sponge count and that he was not negligent in not having made a manual examination or an x-ray examination of the patient's abdomen to make sure that no sponge had been left in the patient's body. The physician was not liable under the doctrine of *respondeat superior* for the nurses' negligence in making the sponge count. Although the nurses were generally under the physician's direction and control during the operation, they were not under his direction and control with respect to the making of the sponge count. The making of the sponge count and the manner of doing so was part of the hospital's routine procedure.

Although the cash value of charitable services rendered by the hospital was relatively small, the evidence clearly established that it was not operated for profit. It was therefore protected from liability under the doctrine of charitable immunity, a doctrine long recognized in Louisiana. If the doctrine is to be abandoned, such action must be taken by the legislature or the Louisiana Supreme Court, the appellate court said. However, the protection of the doctrine was personal to the hospital and was not available to its insurer.

The insurer had refused to defend the suit against the hospital on the ground that it came within the policy provision which excluded coverage for a claim based on a charge of fault in the rendering of medical, surgical, or nursing services. The counting of sponges could not be considered a medical or professional operation. It is merely an administrative function, and negligence in the performance of it was within policy's coverage.

Even if it could be said that the miscount of the sponges was a medical or professional act, the question was such a controversial one that the insurer should have undertaken the hospital's defense. The hospital was entitled to recover from the insurer the expenses it incurred in defending the suit. There was expert testimony that the attorney's fee of $6,000 was reasonable in view of the amount of work done.—*Grant v. Touro Infirmary*, 207 So.2d 235 (La., Feb. 5, 1968; rehearings denied, March 4, 1968).

Conviction for Drug Sale Without Prescription Reversed—A pharmacist's conviction for having sold prescription drugs without a prescription was reversed by the Iowa Supreme Court. The statute under which the pharmacist was tried was too vague to be enforced and provided no ascertainable standard of guilt.

The evidence established that the pharmacist sold a quantity of amphetamine sulfate tablets, a prescription drug, for $50 to a man who

had no prescription. The statute under which the pharmacist was tried prohibited the sale of prescription drug without a prescription and prescribed penalties for the statute's violation. The statute also provided that nothing in it should be construed to prevent a licensed physician, dentist, nurse, veterinarian, or pharmacist from doing acts necessary in the ethical and legal performance of his profession.

The court said that although it did not approve of what the pharmacist allegedly did, it had to consider the statute as it applied to licensed practitioners generally. The statute provided no standard or guide as to what was ethical in the practice of the listed professions. The statute thus provided no ascertainable standard of guilt and was unworkable.—*State of Iowa v. Webb*, 156 N.W.2d 299 (Iowa, Feb. 6, 1968).

Husband Liable for Support of Child Conceived by Artificial Insemination—A husband was convicted for failure to support a child conceived by his wife through artificial insemination with the semen of a third-party donor. The court held that the husband was the lawful father of the child within the meaning of the nonsupport statute. The Supreme Court of California affirmed the conviction.

After eleven years of marriage, the husband was medically determined to be sterile, so he consented to heterologous artificial insemination of his wife. After the couple signed an agreement requesting a physician to inseminate the wife the physician treated her. She became pregnant, gave birth to a male child and for four years the family had a normal family relationship, with the husband treating the child as his own son. The couple was then divorced. The former husband was convicted for nonsupport when he refused the district attorney's request to pay child support.

The statute provides that the father of a legitimate or illegitimate minor child is liable for nonsupport of the youngster. A child conceived through artificial insemination does not have a "natural" father, the court said. The anonymous donor of the sperm cannot be considered the natural father because he is not responsible for the use made of his sperm. Since there is no natural father, the term "father," as used in the statute, cannot be limited to the biologic father. The determinative factor is whether a legal relationship of father and child exists. The court held that since the husband consented to the production of the child, he also assumed the legal responsibilities of fatherhood including criminal responsibility for nonsupport. The object of the statute is to provide for the youngster and to protect the public from the burden of supporting a child who has a parent able to support him. It would be unjust if a child conceived through heterologous artificial insemination with the consent of the husband were excluded from the benefits of a law intended to protect all minors.

Since the statute protects both legitimate and illegitimate children, it was not necessary to determine if the child was legitimate. However, the court noted that since an illegitimate child is one born of parents not married to each other, then, in the absence of legislation prohibiting artificial insemination, the offspring of the husband's legal marriage to the child's mother would not be the product of an adulterous relationship. The court refused to decide the child's legal status because legitimation is a subject for legislative action.—*People v. Sorensen*, 66 Cal. Rptr. 7 (Cal., Feb. 26, 1968).

Hospital Staff Privileges Improperly Reduced—The reduction of a physician's staff privileges by the executive committee of a public hospital was invalid, the Michigan Supreme Court ruled. The bylaw under which the committee acted violated due process, because it attempted to confer arbitrary power on the committee with respect to the reduction of staff privileges. The bylaw provided that the committee could reduce a physician's staff privileges if, in its opinion, it appeared that the reduction would be "to the best interest of the hospital and its patients."

The committee notified the physician that it had concluded that his handling of a certain case had been inadequate, inappropriate, and improper, and prohibited him from using narcotic drugs beyond 48 hours without the written approval of the department chief.

The physician's license to practice in the state included the right to practice in public hospitals, the court pointed out. Due process required the committee to act on the basis of reasonable standards in restricting his staff privileges. Since the bylaw contained no requirements as to the physician's knowledge, skill, character, or conduct, it attempted to confer on the committee the arbitrary power to reduce privileges according to its whim or caprice, subject only to appeal to the staff and ultimately to the board, whose powers of review were equally arbitrary.

After the physician filed this suit, the list of staff appointments for the following year was announced. The physician was not reappointed. The trial court denied his motion to amend his complaint so as to raise the issue of the validity of the failure to reappoint him. That issue remains to be disposed of.—*Milford v. People's Community Hospital Authority*, 155 N.W.2d 835 (Mich., Feb. 9, 1968). ◄

ABSTRACTS, BOOK REVIEWS

HEREDITY, DISEASE, AND MAN: GENETICS IN MEDICINE

Alan E. H. Emery, M.D., University of California Press, Berkeley, 1968; 247 pp.; $6.95.

This interesting book is written by the Chairman of the Department of Human Genetics, University of Edinburgh. It is one of a series of books on medical subjects, with Leo van der Reis, M.D., as general editor, written in lay language for the edification of non-medical readers; for use by medical graduates for review and for paramedical persons who desire broad knowledge of the subject.

It starts with Mendelism and proceeds in an orderly and easy to read fashion with the development of genetics, the chemistry of inheritance to chromosomes and their abnormalities and the relation of genetic factors and disease. One chapter considers radiation and heredity and the final chapter is devoted to genetics and the physician.

It is as fascinating as a detective story. Good reading for any physician, recommended for high school students interested in biology and a must for college students. It is an example par excellence of the art of explaining a highly technical subject in, for the most part, layman's language.

FRANK B. RAMSEY, M.D.
Editor

A TEXTBOOK OF NEUROLOGY

H. Houston Merritt, M.D., 4th edition, Lea & Febiger, Philadelphia, Pa., 1967; XX plus 844 pages; $15.00.

This work is a typical textbook in format, typography, and weight, but not in diction, which (a la Merritt) is unusually clear, sharp and concise. In this book, understanding of the neurological situation in any disease or syndrome is strikingly enhanced by correlation of all the other systems of the body which may be affected. Thus the entire medical picture is retained in proper perspective. This result is greatly facilitated by an approach based on etiology, wherever possible.

An important section of the book is devoted to metabolic disease, and includes consideration of endocrine glands; diseases of the blood, the liver, collagen tissues and bone; inborn metabolic defects; disorders of lipoid, carbohydrate, mucopolysaccharide, porphyrin and metal metabolism; and also the polyneuritides, albeit some of these are toxic rather than metabolic.

Trauma is given its full share of attention, and this chapter should be of especial value in everyday practice in the present state of our society and of our means of transportation. Injury to the brain and also to the spine and peripheral nerves is all too common. Trauma to intervertebral discs and the effects of electricity and decompression sickness are also discussed.

The illustrations are well reproduced with clear legends and free use of guiding arrows. No attempt is made in this review to give a complete outline of the book, since it is a fourth edition, but attention is called to the excellent presentation of subject matter and to the validity of revisions and additions, which amply justify a new edition. Truly, an excellent volume for any physician's bookshelf.

A. W. CAVINS, M.D.
Terre Haute

BABY AND CHILD CARE

Benjamin Spock, M.D., Pocket Books, New York, 1946; (170th printing, 1967); 627 pp.; $0.50.

This is a review of the book and not a review of Dr. Spock's latter-day political ideas and actions.

I don't know why this book is sent to us at this time. Over 20 million copies have been sold. It is *the* best seller. No other pocketbook has been so popular. Probably only the Bible has been so widely printed. This is the bible of baby and child care. Bad reviews at this time will change nothing.

Probably the publisher wants to publicize a little controversy between it and Dr. Spock. Inserted in approximately the middle of this volume are sixteen pages of advertisement and pages for notes and records. The publisher feels this helps pay for the book. Dr. Spock feels this represents an unethical endorsement by him. Both are correct. In the unlikely happenstance that the book is losing money, the price should be raised to 75¢ and the advertisement left out. The advertisement section could be torn out of this book except the pages for notes and records are interspersed. What a coincidence!

For those other than the 20 plus million who own the book, it is a neat readable little volume explaining how the parents of 1946 can "take it easy" and the parents of 1968 can "keep it cool" while their offspring grow, develop and become parents themselves. Included is advice to parents; equipment and clothing needed; medical and nursing needs; basic philosophy about who's boss; infant feeding (breast feeding and bottle feeding); vitamins and water advice; scheduling; daily care advice. Other topics concern problems of infancy, inoculations, development, toilet training. Then progressive problems of the one year old, two, three-to-six, six-to-eleven. Special problems considered are schools, puberty, feeding, illness, first aid, etc.

This is a good book to recommend to parents.

ALVIN J. HALEY, M.D.
Fort Wayne

ATLAS OF INTESTINAL STOMAS

R. B. Turnbull and Frank Weakley, C. V. Mosby & Co., St. Louis, Mo., 1967; 207 pages with 182 illustrations; $21.50.

As a former general practitioner turned internist, I am really less than the expert who should be judging the pages of this fantastically detailed and beautifully illustrated, step-by-step analysis of a "do it yourself" surgical manual.

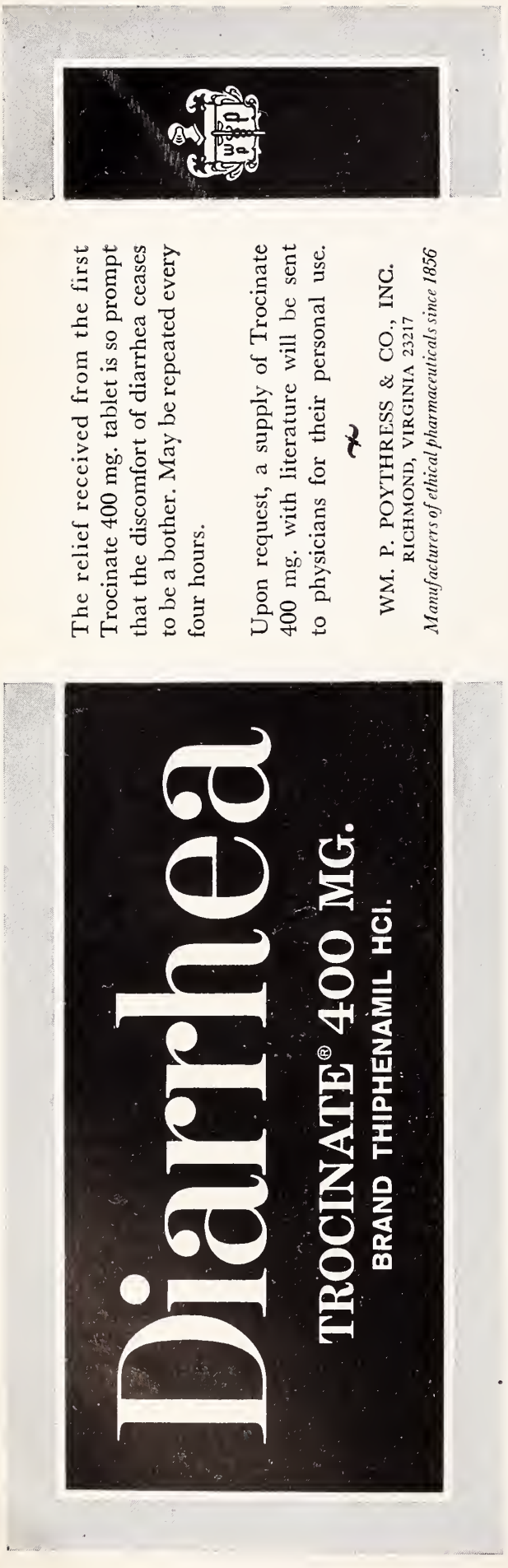
The presentations are so compact, complete and understandable that NO general surgeon — to say nothing of the specialist in the field — can afford to be without an accessible copy. Here is something to scan, ponder: and then return to for another look.

The binding and printing are excellent. And then, the illustrations! Ah, the *ILLUSTRATIONS!* They are something out of this world making the price for the monograph seem a paltry pifflc.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

HEALTH OF MANKIND

Ciba Foundation Symposium, edited by Gordon Wolstenholme & Macve O'Connor, Little, Brown & Co., Boston, Mass., 1967;



296 pp.; 11 tables; $12.00.

More than two dozen truly distinguished experts have pooled their respective expertises in order to discuss in depth the world population explosion, to give insight into regional problems being created — and even to outline some very tentative solutions that can be offered here and now.

It is grim to contemplate the fact that ONE American farmer produces the equivalent of FIFTY Indian peasants! If births outstrip increases in food supply — how can total disaster be avoided?

The questions are very real, very current and loaded with horrifying implications. We doctors have an especial duty to reflect on reading volumes such as this one. The total community will be looking to us for answers to problems really insoluble in the context of our present customs and mores.

The binding and paper, as usual, are excellent. Surprisingly, Figures 6, 7 and 8 are printed upside down! These typographical errors detract but very little from the readability of the symposium as such.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

Abstracts From Various Literature, Prepared by AMA

TWO CASES OF FATAL SALICYLATE POISONING AFTER TOPICAL APPLICATION OF AN ANTIFUNGAL SOLUTION

C. P. Lindsey (Bougainville, Solomon Islands)

Med. J. Aust. 1:353-354, (March 2), 1968.

Two cases of death from salicylate poisoning due to topical application of 20.7% salicylic acid in alcohol are described.

CARDIOVASCULAR FUNCTIONS AFTER RESUSCITATION BY OPEN-CHEST CARDIAC MASSAGE

F. Burkart and J. H. Dunant (Kardiologische Abteilung der Medizinischen Universitats-klinik, Basel, Switzerland)

Deutsch Med. Wschr. 93:475-479, (March 15), 1968.

Reexamination of 19 of 22 patients who had been discharged from the hospital after successful resuscitation by open-chest cardiac massage was undertaken 11 to 12 years later (mean of four years). Clinical, ECG, and radiological findings are reported. The prognosis of work capacity in those who had been successfully resuscitated depended principally on the degree of cerebral recovery.

MANAGEMENT OF PILONIDAL SINUS

F. O. Stephens and D. R. Sloane (Sydney Hospital, Sydney, Australia)

Med. J. Aust. 1:395-396, (March 9), 1968.

A technic is described for treating pilonidal sinus by injection of full-strength phenol followed by the use of a depilatory cream to maintain the area free from hair. The technic is simple to apply and painless, and allows the patients to return to work within a few days. The preliminary results in our first 20 cases over a period varying from three months to two years have been most encouraging, but a longer period of evaluation is required.

COMPLICATIONS ASSOCIATED WITH USE OF INTRAUTERINE CONTRACEPTIVE DEVICES IN WOMEN OF MIDDLE AND UPPER SOCIOECONOMIC CLASS

J. R. Willson and W. J. Ledger (University of Michigan Medical School, Ann Arbor)

Amer. J. Obstet. Gynec. 100:649-661, (March 1), 1968.

Complications associated with the use of intrauterine contraceptive devices by 710 women of middle and upper class social strata over a total period of 14,901 woman-months are described. Bleeding was the most frequent, occurring in almost all women and persisting in 41%. There were three perforations and infection occurred in 1.3%. The pregnancy rate was 2.51/100 woman-years of use. Other complications were minor, having little effect on general health or reproductive function. Since most of the complications were either minor or avoidable, this form of contraception, when properly used, has many advantages over conventional methods.

STUDY OF SURVIVAL IN 279 CASES OF HODGKIN'S DISEASE

C. W. Boyer, Jr. (Walter Reed General Hospital, Washington, D.C.), T. J. Brickner, Jr., and R. H. Perry

Amer. J. Roentgen. 102:613-618, (March), 1968.

In the series of Hodgkin's disease treated at Walter Reed General Hosp., improvement in survival was apparent in the early stages when prophylactic areas were irradiated. With the present staging system there may be little value in differentiating between stage I and IIA since survival at five and ten years is the same in each stage. Supervoltage equipment has made it possible to irradiate larger volumes of tissue to higher doses than was possible in the orthovoltage era, and possibilities for cure in the earlier stages are better. The most important prognostic feature in this disease is its evident extent when the patient presents himself for treatment. When there is localization of disease to the lymphatic regions on one side of the diaphragm, survival free of disease can be expected using properly directed radiation therapy. Optimism is no longer an unrealistic attitude.

VAGOTOMY AND DRAINAGE PROCEDURES FOR GASTRIC ULCER

E. A. Stemmer et al. (5901 E. Seventh St., Long Beach, Calif.)

Arch. Surg. 96:586-592, (April), 1968.

During a 15-year period (1950 to 1965), 18 patients underwent a drainage procedure with or without vagotomy for a benign gastric ulcer. This series was analyzed for operative mortality, incidence of recurrence, completeness of vagotomy, presence of gastric retention, and length of postoperative period before demonstration of recurrence. Of those patients undergoing vagotomy and drainage procedure, 36% developed recurrence within the ten-year period following operation. The average interval to demonstrated recurrence was 5.2 years, with one of the patients developing recurrence 6.2 years following operation. Gastric retention did not appear to be a factor in the development of recurrence, nor did the completeness or incompleteness of vagotomy. During the same period, 118 patients underwent subtotal gastrectomy for benign gastric ulcer. There were no demonstrated recurrences of gastric ulcer in these patients with an average follow-up of 48 months. Subtotal gastrectomy provides a more certain cure of gastric ulcer than do vagotomy and pyloroplasty.

HELICOPTERS FOR EMERGENCIES

K. Whisenand (Doctors Hospital, Mobile, Ala.) and T. Sparling

Hosp. Prog. 49:68-71, (March), 1968.

A twilight zone in the overall management of the injured exists at present from the time of the accident until the patient reaches a medical facility. It is during this period that inadequate or inept initial care and transport of the injured may lead to irreparable physical impairment. Twenty-five percent of those persons permanently disabled in traffic accidents would not be crippled with proper care and transportation after the accident. A survey conducted in a 70-mile radius around St. Louis indicates that helicopters should be used for emergencies, and this report provides surprising answers to other related questions. Contrast between the use of helicopters for the injured in Vietnam compared to the lack of similar transportation in a United States freeway pile-up is striking. Ten million dollars is to be spent on a research campaign for helicopter usage in auto accidents by the National Traffic Safety Bureau and the National Highway Safety Agency in the Department of Transportation; this will no doubt accelerate the use of helicopters.

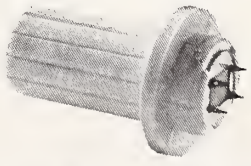
IDIOPATHIC POLYNEURITIS AFTER SURGERY

B. G. Arnason and A. K. Asbury (Massachusetts General Hospital, Boston)

Arch. Neurol. 18:500-507, (May), 1968.

Six cases of idiopathic polyneuritis following a surgical procedure by one to four weeks are reported. These six cases represent approximately 10% of all cases of idiopathic polyneuritis seen during the same period. All six patients progressed to the point of quadriplegia and required ventilatory assistance with a respirator. Two deaths occurred, and inflammatory polyneuritis was confirmed pathologically in both. Other than the preceding surgical procedure, no common denominator was discovered in these six cases. Surgery may trigger a chain of immunologic events culminating in polyneuritis. ◄

Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?
or
HISTO?
(Histoplasmosis—"The Masquerader")



A new aid in differential diagnosis
HISTOPLASMIN, TINE TEST
(Rosenthal)
The LEDERTINE™ Applicator with the Blue Handle

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle

Ask your representative for details or write Medical Advisory Dept.
Lederle Laboratories, Pearl River, New York 10965

Blue Cross and Blue Shield Return Most in Benefits

(One of a series prepared by Blue Cross-Blue Shield)

Blue Cross and Blue Shield Plans in 1967 returned to their members in benefits 85.8% of earned subscription income. All other health insurance returned 75.2%.

More than $8.716 billion was collected by the commercial segment of the health insurance industry during the year, and claims incurred totaled more than $6.550 billion. Blue Cross and Blue Shield Plans earned subscription income was more than $4.968 for 1967, and claims expense was $4.264 billion.

Data for commercial insurers was compiled by the National Underwriter Company. Data for Blue Cross and Blue Shield was furnished by the Blue Cross Association and the National Association of Blue Shield Plans.

The breakdown by type of coverage:

	Premiums Earned Less Dividends	Claims Incurred	Benefits Returned
1. All Health Insurance Except Blue Cross, Blue Shield and other hospital-medical organizations	$8,716,453,313	$6,550,452,262	75.2%
2. Group Health Insurance Except Blue Cross, Blue Shield and other hospital-medical organizations	$5,968,608,859	$5,226,166,856	87.6%
3. Non-Cancellable	$ 347,788,974	$ 141,369,250	40.6%
4. Guaranteed Renewable	$ 810,056,264	$ 414,270,343	51.1%
5. Other Individual Health Insurance	$1,589,999,216	$ 768,645,813	48.3%
	Earned Subscription Income	**Claims Expense**	**Benefits Returned**
Blue Cross and Blue Shield Plans	$4,968,223,119	$4,264,013,099	85.8%

W. C. Huddlestone
Public Relations Division

WANTED: Physicians Locations

GENERAL PRACTICE

Richard Vick Crowley, 1199 Daleville St., Ozark, Ala. 36360

Marvin L. Nice, 114 Belvidere Ave., Forest Park, Ill. 60130

SPECIALISTS

John Ippensen, No. 3 Columbine Court, Apt. #3, Cincinnati, Ohio 45231—*Ear, Nose and Throat*

Earl Paul Gelman, Glenham Green 6B, Fishkill, New York 12524—*OB-GYN*

Mamerto M. Jose, 106 Walnut, Terrell, Texas 75160—*OB-GYN*

Bong Oh Kim, 28B V.A. Hospital, Marion, Ind.—*Pathology*

Richard Alan Wham, 3541 Royal Palm Dr., Virginia Beach, Va. 23452—*Radiology*

M.H. Bate', 1214 Lakewood Drive, Montgomery, Ala. 36109—*General Surgery*

Najed K. Chaarani, Rue Fouad 1st Kinj Bldg., Beirut, Lebanon—*General Surgery*

William F. Dippel, 1426 S. Wolf Rd., Des Plaines, Ill. 60016—*General Surgery*

Rolland E. Greenburg, Naval Air Station, Alameda, Calif. 94501—*Surgery*

Marcos Y. Que, 8th Fields Hospital, Vietnam, APO San Francisco 96240—*General Surgery*

William Robert Rundles, 1665 North "F" Street, Pensacola, Fla. 32501—*General Surgery*

Ki Taek Song, P.O. Box 494, VA Center, Dayton, Ohio 45428—*General Surgery*

Mario Verna, 10 Prospect Ave., Apt. 17, Hackensack, New Jersey 07601—*General Surgery*

W. M. Kale, 2504 Carol Drive, Big Spring, Texas 79720—*Surgery-Thoracic and Cardiovascular*

Bruce Bayley, 309 Chicago Ave., Oak Park, Ill. 60302—*Urology*

Robert Jay Rosenberg, 1222 N. 116th St., Milwaukee, Wis. 53226—*Urology*

Thomas P. Magenis, P.O. Box 3955, Portland, Ore. 97210—*Teaching Physiology or combination*

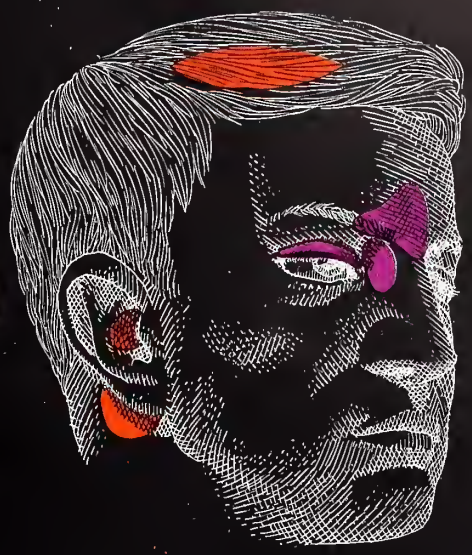
ADDITIONAL LOCATIONS

County Town

Howard—KOKOMO—population 49,900. Two hospitals—one 148 beds and the other 223. Openings for: One general practitioner and one internist desired to join a busy group of two general practitioners, one OB-GYN, and one surgeon in a growing industrial city of 50,000. Salary $24,000 to start, with increases and partnership available. Write or phone: Robert E. Thompson, Business Manager, 401 E. Reynolds Dr., Kokomo, Ind., phone 453-0802.

Scott—SCOTTSBURG—population 3,850—county seat town located in south central Indiana, with a 35 bed hospital. Openings for two general practitioners. Contact Thomas Neathamer, M.D., N. Gardner & White Sts., Scottsburg, Ind. 47170. ◄

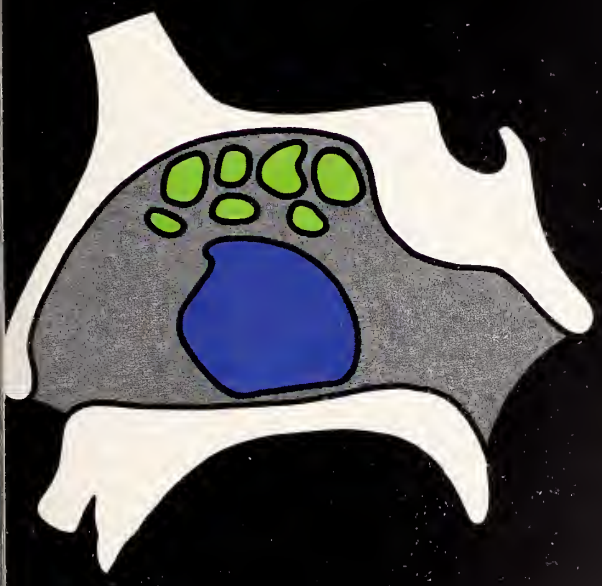
Sources of sinus headache



REGION OF SENSATION

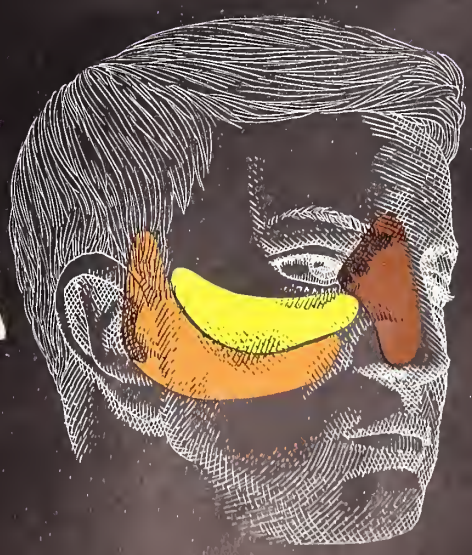
FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids.

SPHENOID SINUS—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.



MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.

ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.



TURBINATES—pain along medial and lateral walls of the inside of the nose. Headache in frontal region, along supraorbital ridge, a feeling of fullness in the head.

Source of symptomatic relief

SINUTAB

Sinus headache is often a reflection of congestion in the nasal mucosa. The pain that results in the various regions of the head may help in determining the particular structure(s) responsible. The Sinutab formula is specifically designed for symptomatic relief of sinus headache and nasal congestion. **Sinutab** *not only* **provides an effective decongestant** — to reduce mucosal engorgement and facilitate freer breathing — *and* **an antihistamine** — to help reduce edema and excessive secretions — but it *also* provides, in contrast to other leading decongestants, **two analgesics** for immediate relief of pain and discomfort.

And, too, the Sinutab dosage schedule of 2 tablets, *q.* 4 *h.* permits controlled and continuing analgesic relief.

Adverse Reactions: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

Precautions: Instruct patients not to drive or operate machinery if drowsiness occurs. Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

Dosage: Adults—2 tablets every 4 hours.

Each tablet contains 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

SPECIFIC FORMULA **SINUTAB®** FOR SINUS HEADACHE

Also Available on Prescription:

Sinutab® with Codeine.* Each tablet contains 15 mg. (¼ gr.) codeine phosphate (Warning: May be habit forming), 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

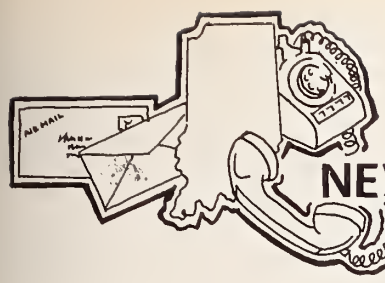
Sinutab® Pediatric Suspension. Each 5 ml. teaspoonful contains 300 mg. acetaminophen, 12.5 mg. phenylpropanolamine HCl, and 10 mg. phenyltoloxamine citrate.

*Subject to Federal Narcotics Regulations.

For 1 complimentary bottle of 30 Sinutab tablets, write: J. S. Travis, Warner-Chilcott Laboratories, Morris Plains, N.J. 07950. Please mention this journal.

S-IN-81-4C

WC **WARNER-CHILCOTT** Morris Plains, N.J.



NEWS NOTES

Indiana's J. Irwin Miller Named To AMA Advisory Committee

Nine distinguished laymen have been named to a committee which will advise the American Medical Association on present and future health care needs of the nation.

Formation of the Advisory Committee on Health Care of the American People was described by Wesley W. Hall, M.D., chairman of AMA's Board of Trustees, as "designed to further open the door to communication between physicians and leaders in other fields.

"Social and economic aspects of health care are the concern of our whole society," Dr. Hall said "and the AMA wants to obtain through this committee the advice and suggestions of respected representatives of business, education, religion, law, government, women's organizations, labor, minority groups, publishing and other social and professional elements."

Named chairman of the committee was Charles E. Odegaard, Ph.D., president of the University of Washington, Seattle. An historian, Dr. Odegaard is a member of the National Council on the Humanities and of the National Advisory Health Council of the U.S. Public Health Service.

"I hope that I may be of some use to the American Medical Association in its taking the actions needed to advance and improve health care in the United States," Dr. Odegaard said.

Named vice-chairman of the committee was Judge Warren E. Burger of the United States Court of Appeals, Washington, D.C. He is a former assistant attorney general of the United States.

Other committee members named were:

* J. Irwin Miller, chairman of the board, Cummins Engine Co., Inc., Columbus, Indiana. Mr. Miller is a former president of the National Council of the Churches of Christ in the U.S.A., and is a director of the American Telephone and Telegraph Co., the Equitable Life Assurance Society of the United States and Purity Stores, Inc.

* Charles B. Shuman, president of the American Farm Bureau Federation, Chicago. Mr. Shuman operates a 270-acre stock and grain farm near Sullivan, Ill.

* The Rev. Thomas J. O'Donnell, S. J., Director of the Jesuit Residence, Hot Springs, N.C., a unit of the Educational and Missionary Institute of the Society of Jesus in North Carolina. Father O'Donnell, an educator, author and theologian, is a former regent and dean of students and professorial lecturer in medical ethics at Georgetown University School of Medicine.

* Kermit Gordon, economist and president of the Brookings Institution, Washington, D.C. Mr. Gordon served as budget director during the administrations of Presidents Kennedy and Johnson and formerly was a professor of economics at Williams College.

* Miss Ann Landers, author of the world's most widely syndicated newspaper advice column. A resident of Chicago, Miss Landers was cited in a national poll in 1967 as one of the world's ten most influential women.

* John H. Johnson, president of Johnson Publishing Co., Inc., and publisher and editor of *Ebony*, *Tan*, *Jet* and *Negro Digest* magazines. In 1951, Mr. Johnson of Chicago, was selected as one of the nation's 10 outstanding young men of the year by the United States Junior Chamber of Commerce.

* Edward Swayduck, of New York City, president of Local One, Amalgamated Lithographers of America. Members of the union have re-elected Mr. Swayduck to his post 10 times since 1948.

Further appointments to the committee are expected to be made soon, Dr. Hall said.

The committee will meet periodically with the AMA's trustees and other officers, he said.

Albert Bowers Elected

Albert Bowers, Ph.D., president of Syntex Laboratories has been elected to the Board of Directors of Syntex Corporation. Syntex Laboratories manufactures and markets prescription drugs for human and veterinary medicine.

Drs. Collins, Phillips At Heart Conference

Dr. Jack T. Collins and Dr. John F. Phillips, Bluffton physicians, recently attended the American Heart Association annual meeting and scientific sessions in San Francisco.

Schering Corporation Aids Minority Youth; Hospital Personnel Shortages

The Schering Corporation is coping with two major problems, the employment of minority youth and a shortage of trained health personnel, by establishing a program which will enable 30 students to participate in an eight-week summer program in which each student will spend a week or more, under professional supervision, in various hospital departments.

Schering is providing an educational stipend for each week of participation. This is a pilot program and will be subjected to careful analysis on completion for information of other institutions across the nation.

Dr. Matthew Speaks

Dr. W. Burleigh Matthew, Indianapolis ophthalmologist, recently spoke at Logansport on his visits to the Hyderabad area of India. Dr. Matthew has been involved in building a 25-bed hospital at Kamalnagar, building a leprosy eradication center at Udgir, electrifying Kamalnager Hospital, and sending over 128 tons of medical supplies and materials to ten mission hospitals in India and to World Medical Relief, Detroit.

Dr. Offutt Speaker

"Challenge to the Future in Aging" was the topic of **Dr. Andrew C. Offutt,** state health commissioner of Indiana, when he spoke at the Kennedy Memorial Christian Home, Martinsville, where members of the medical profession and their wives were guests.

Purdue to Conduct Major Fund-Raising Campaign

Purdue University, as a part of its Centennial Celebration next year, will conduct a major multi-million dollar fund-raising campaign. Five major objectives have been announced as vitally necessary for the future of the university.

The proposed fund will contribute to a new "Centennial" Library; to construction of an Engineering Graduate Research Center; to a Telecommunications Center; to the continuing education program and to an endowment fund for outstanding teachers, researchers and graduate students.

Continued

NEWS NOTES

Continued

Dr. Bowers Gives Lecture

Dr. C. Richard Bowers, Anderson, gave a lecture pertaining to his recent tour of duty at provincial hospitals in Vietnam at a meeting of the Soroptimist Club of Anderson.

Dr. Baker Honored

Dr. Guy D. Baker, Crandall, was recently honored by the Masons at the Crandall Community Hall. Dr. Baker has delivered several thousand babies in the county and it is believed that he is one of the last of the "horse and buggy" doctors.

Dr. Slaughter is Speaker

Dr. John C. Slaughter, Jr., Evansville, spoke on "Holidays For Humanity, Inc.," which he and his wife, Margaret, founded, at a recent meeting of the Mt. Vernon Kiwanis Club. The not-for-profit organization sends physicians, dentists, nurses, teachers and other personnel to clinics in the Central America area on a voluntary basis and also ships large quantities of medications, medical supplies, used clothing, etc., to the poor people.

Dr. Baptisti, Jr. is Speaker

Dr. Arthur A. Baptisti, Jr., Indianapolis, recently spoke to the members of the Women's Auxiliary of the Athenaeum Turners on his three voyages aboard the hospital ship S. S. HOPE.

Indiana Woman's Auxiliary Receives AMA Achievement Award

The Woman's Auxiliary to the Vanderburgh-Southwestern Medical Society of Indiana received the achievement award on a national basis for auxiliaries of 101 to 200 members for its contribution of $3,613.50 to the American Medical Association Education and Research Foundation.

The announcement was made at the AMA auxiliary meeting in San Francisco in June. The total contribution for all auxiliaries of the AMA for this year was $357,374.78.

Panel of Doctors Give Talks

Emergency problems which any fireman could encounter on duty was discussed by a panel of four Richmond physicians at a recent session of the East Central Fire Conference.

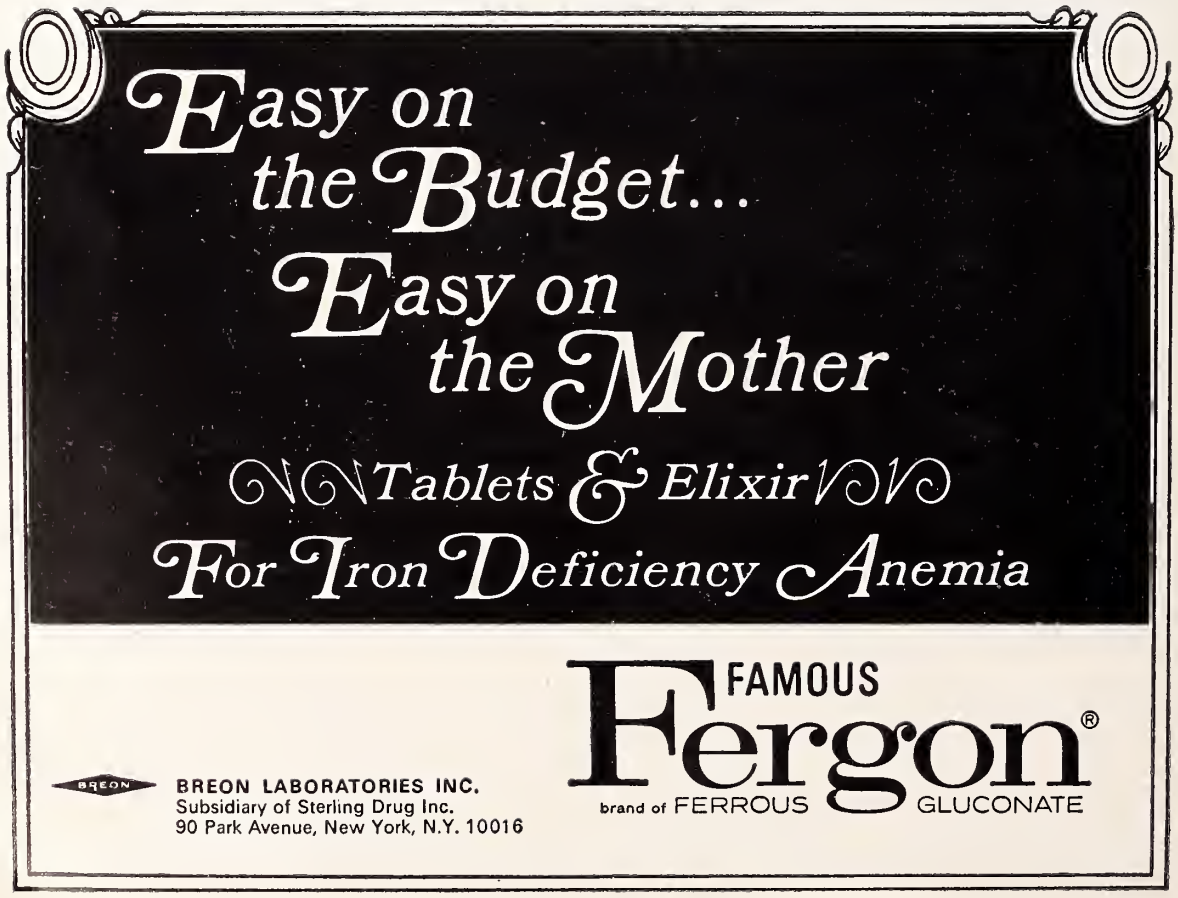
Dr. James R. Guthrie spoke on the psychological stress of the fireman's job. **Dr. Glen A. Ramsdell's** topic was the fireman's role in resuscitation. **Dr. John F. Ling** talked on the nature of heart disease and **Dr. Charles H. Loomis** explained the importance of care to persons who have been burned or injured.

Dr. Bobb Gives Talk

Dr. Kenneth Bobb, Seymour, presented a talk on hospital accreditation, when the Seymour League of Women Voters met recently.

Syntex Corporation to Form Two New Corporations

The Syntex Corporation will form two new corporations for



advanced research projects. One will work on the development of hormonal methods for insect control. This type of research has been carried out by Syntex for several years and is now so well developed that it can best be done by a separate organization.

The other corporation will engage in research on drug-delivery systems. It is to be named ALZA Corporation and will seek new ways to deliver drugs within the body.

Four Doctors Join Panels

Four Fort Wayne doctors participated in a program during a recent symposium in Indianapolis of the Indiana Academy of General Practice and the Indiana Section, American College of Obstetricians and Gynecologists.

Dr. John W. Rousseau was moderator for a panel discussion of "Heart Disease in Pregnancy." **Dr. Alvin J. Haley** was a panel member on "What's New?" **Dr. Marvin E. Priddy** was moderator on a panel discussion on "Clomide" and **Dr. Lewis W. Knight** acted as moderator for a panel discussion of "Common Problems in Pregnancy."

Dr. Starks Elected

Dr. William O. Starks, Anderson, has been elected vice president of the board of directors of United Cerebral Palsy of Madison County.

Dr. Hamilton in Las Vegas

Dr. Charles O. Hamilton, South Bend anesthesiologist, recently attended the annual meeting of the American Society of Anesthesiologists in Las Vegas, Nevada. Dr. Hamilton has been secretary of the organization since 1963 and was program moderator for a workshop panel at one of the sessions.

Dr. Schlademan is Speaker

Dr. Karl R. Schlademan, Fort Wayne, discussed "Gynecologic Cytology" at a recent meeting of the Fort Wayne Academy of Medicine and Surgery.

Drs. Offutt and Ganser Named

Dr. Andrew C. Offutt, State Health Commissioner, has been named as secretary to the Hearing Aid Dealer Advisory Committee. **Dr. Ralph Ganser,** South Bend, has also been appointed to the committee, which is part of a 1967 law regulating the sale, lease or rental of hearing aids.

Dr. Haller Participates in Convention

Dr. Thomas C. Haller, Crawfordsville, recently attended the annual convention of American College of Gastroenterology in Los Angeles. Dr. Haller served as one of the convocation committee marshals.

Dr. Fausset is Speaker

Dr. C. Basil Fausset, Indianapolis, spoke on "Cervical Spine Disk and Associated Conditions" at a recent meeting of the Indiana Division of the International College of Surgeons at Bloomington.

Dr. Salon Attends Conference

Dr. Nathan L. Salon, Fort Wayne, chairman of the Indiana Commission on the Aged and Aging, recently was in Baltimore for the American Medical Association's Conference on Aging and Long-Term Care.

Dr. Rogers is Speaker

Dr. Evered E. Rogers, Auburn, DeKalb county health commissioner, recently spoke at the meeting of the Auburn Rotary

Q. How much does the **anticostive*** **hematinic** cost?

A. No more than costive hematinics cost!

The anticostive hematinic is

PERITINIC®

Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

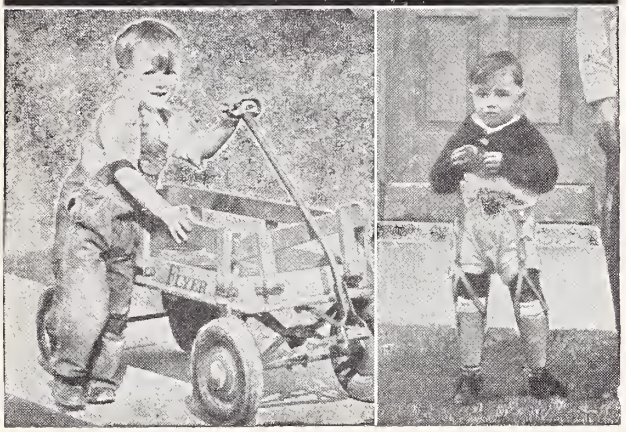
*

anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

490-7R- 6014

"... he runs and plays again!"



Hanger Prosthetic Appliances have brightened the present and the future for many amputees. For example, Weaver Nolt says: "My son, Lloyd, was a pathetic figure in a big hospital bed after his legs were amputated because of an accident. Today it's a big and wonderful world again as he gets along so wonderfully on his Hanger legs. He walks without any help, and runs and pushes his wagon all over the farm. That other day is just a hazy memory, and we are so pleased things are so different than we expected.

Hanger PROSTHESES

1332 N. Illinois St., Indianapolis, Ind. 46202
3108 Burnet Avenue, Cincinnati, Ohio 45229
446 W. Pontiac Street, Fort Wayne, Ind. 46807
416 N. Main St., Evansville, Ind. 47711

NEWS NOTES

Continued

club. Dr. Rogers told of the expansion of the duties of his office since he was appointed to the post 20 years ago.

Dr. Alexander Speaks to Baby Sitters

Dr. Jack L. Alexander, Muncie pediatrician, discussed "The Medical Aspects of Babysitting" at a recent meeting of the Jayshees Baby Sitters' Clinic.

Dr. Zydlo at Seminar

Dr. Stanley M. Zydlo, Wabash physician, was recently at Selfridge AFB, Michigan where he participated in a one-day Fifth Air Force Reserve Region medical seminar as an Air Force Reservist.

Dr. Gutierrez Gives Address

Dr. Peter E. Gutierrez, Gary, recently delivered the commencement address, emphasizing the role of the licensed practical nurse in modern society, for the Practical Nurse Training Program at Purdue University Calumet Campus.

Dr. Matthew Speaks

Dr. W. Burleigh Matthew, Indianapolis eye specialist and physician, recently spoke of his work with neglected peoples of many foreign lands before the Lebanon Kiwanis group.

Dr. Matthew and his wife made a world tour about six years ago and found many countries completely lacking in medical facilities. The Matthew's devote about three months each year to visits abroad and collect medical supplies, eye glasses, band-

HARDING HOSPITAL

WORTHINGTON, OHIO

A fully accredited private psychiatric hospital situated on 45 acres of beautiful, wooded grounds just ten miles north of the state capitol.

THE HARDING HOSPITAL PROVIDES:

* 125 In-patient beds —
* Day Hospital program —
* Full time attending staff of psychiatrists —
* Professionally trained Adjunctive Therapy staff with programs in occupational, recreational and vocational therapy. (Crafts, Fine Arts, Greenhouse, etc.)
* Qualified staff of psychologists —
* Social Service department —
* Consultation and evaluation for out-patients.

For particulars on rates and terms or on specific patients write or call —

Harding Hospital - Worthington, Ohio
Area Code 614 - 885-5381

George T. Harding, M.D.
Medical Director

Donald L. Hanson
Administrator

ages, dressings and many other donated articles to supply clinics overseas.

Dr. Sage Named

Dr. Charles V. Sage, Richmond, has been named medical director for the home office of the Wabash Life Insurance Co.

Dr. Kabel Elected

Dr. Robert N. Kabel, Terre Haute, has been elected president of the Medical and Dental Association of Union Hospital. Other newly elected officers include: Dr. Robert C. Reed, vice president, Dr. Robert O. Lancet, secretary and Dr. Paul E. Davis, treasurer, all from Terre Haute.

Drs. Martz, Dyken Speakers

Dr. Carl D. Martz, medical director of the cerebral palsy clinic at the Indiana University Medical Center, and **Dr. Mark L. Dyken,** I.U. neurologist, discussed the problem of parents of children with cerebral palsy at a recent meeting sponsored by the parents advisory council of the United Cerebral Palsy of Central Indiana.

Dr. Gillum on Panel

Dr. Eugene M. Gillum, Portland, acted as moderator in a panel discussion on "The Unwed Mother" at a recent Symposium of Practical Obstetrics in Indianapolis.

Dr. Wachob on Panel

Dr. Thomas W. Wachob, Jr., Kokomo, was recently on a panel of three discussing "What's New?" at the Symposium on Practical Obstetrics and Gynecology held in Indianapolis.

Dr. Crouse is Speaker

Dr. Ben E. Crouse, Frankfort, spoke on "Drugs and Some of Their Untoward Reactions" at a recent meeting of the Clinton County Registered Nurses Club.

Dr. Bryan Gives Demonstration

Dr. Robert E. Bryan, Kendallville, gave a demonstration and discussion of hypnosis at the recent meeting of the Noble County Extension Homemakers Officers.

Dr. Rusche Joins Staff

Dr. Thomas J. Rusche, Indianapolis, has joined the staff of the Tri-State Epilepsy Association as medical director. The neurologist will work with the epileptic factory employees at Epi-Hap and with those seen through the association.

Dr. Burns Appointed

Dr. Paul E. Burns, Montpelier, has been appointed to the Board of Zoning Appeals. Dr. Burns will serve until January 1, 1971.

Dr. Chamblee Speaker

Dr. Roland W. Chamblee, South Bend, spoke on "Revolution in the U.S.A." at a recent meeting of the St. Joseph Parish Home and School Association.

Dr. Bates is Speaker

Dr. Laurence H. Bates, Indianapolis, spoke at the recent meeting and open house of the state chapter of the National Hemophilia Foundation. ◄

What can be done for Susan Jane To stop the runs and crampy pain?

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin, and protects intestinal mucosa

In children, Parepectolin may be used to control diarrhea promptly and prevent dehydration, until etiology has been determined. In some cases, Parepectolin may be all the therapy necessary.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
Paregoric (equivalent) ..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified) .... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Children's Dose: One or two teaspoonfuls three times daily.

ROER

WILLIAM H. RORER, INC.
Fort Washington, Pa.

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT — June, 1968

Disease	June 1968	May 1968	April 1968	June 1967	June 1966
Animal Bites	1505	1168	949	1626	1476
Chickenpox	185	482	491	117	196
Conjunctivitis	85	116	129	61	131
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	1	12	82	9	37
Gonorrhea	593	465	427	445	497
Impetigo	100	62	67	75	86
Infectious Hepatitis	56	54	31	36	28
Infectious Mononucleosis	53	221	101	34	48
Influenza	189	444	680	50	360
Measles					
Rubeola	69	143	80	60	970
Rubella	63	203	133	62	271
Meningitis, Meningococcal	8	2	1	1	8
Meningitis, Other	9	6	1	1	6
Mumps	234	701	655	509	309
Pertussis (whooping cough)	32	33	41	22	5
Pneumonia	180	166	185	204	419
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	458	629	826	277	513
Syphilis					
Primary & Secondary	25	38	45	16	9
All Other Syphilis	142	124	97	231	119
Tinea Capitis	13	6	10	10	4
Tuberculosis (Active)	128	89	68	113	102

in the treatment of

IMPOTENCE

Android®

(thyroid-androgen) TABLETS

*Effectiveness confirmed by another double blind study**

1. SUMMARY

ANDROID — GOOD TO EXCELLENT 75%

PLACEBO — 20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

*"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths

Android

Each yellow tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY

Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

REFER TO PDR

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

Write for literature and samples:

BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

also available with ESTROGEN

Android-E

Each Tablet Contains:
Methyl Testosterone ..... 2.5 mg.
Ethinyl Estradiol ..... 0.02 mg.
Thyroid Ext. (1/6 gr.) ..... 10 mg.
Thiamine Hydrochloride .... 10 mg.
Glutamic Acid ..... 50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE:** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS:** In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRA-INDICATIONS:** See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION ANNUAL CONVENTION
Date Dec. 1-4, 1968
Place Miami Beach, Fla.

NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville

INDIANA PSYCHIATRIC SOCIETY
Date Second Wednesday of the month October through May, excluding December
Place The Athenaeum, Indianapolis

AMERICAN COLLEGE OF SURGEONS INDIANA CHAPTER
Date April 17-19, 1969
Place Purdue University, West Lafayette

BONE AND JOINT CLUB
Date October 30, 1968
Place Athenaeum, Indianapolis

INDIANA ACADEMY OF GENERAL PRACTICE
Date April 15-17, 1969
Place Evansville

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
Date April 30-May 1, 1969
Place Imperial House, Columbus

INDIANA ASSOCIATION OF PATHOLOGISTS, INC.
Date December 7, 1968
Place Indianapolis Motor Speedway Motel

INDIANA CHAPTER OF AMERICAN ACADEMY OF PEDIATRICS
Date May 14-15, 1969
Place Stouffer Inn, Indianapolis

INDIANA DENTAL ASSOCIATION
Date May 10-14, 1969
Place Murat Temple and Essex House Motel, Indianapolis

INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY
Date October 9, 1968
Place Marott Hotel, Indianapolis

INDIANA PUBLIC HEALTH ASSOCIATION, INC.
Date April 22-24, 1969
Place Stouffer Inn, Indianapolis

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 15-18, 1968
Place Fort Wayne

INDIANA ROENTGEN SOCIETY
Date May 4, 1969
Place Holiday Inn, Indianapolis

INDIANA SOCIETY OF ANESTHESIOLOGISTS
Date May 24, 1969
Place Marott Hotel, Indianapolis

INDIANA STATE LICENSED PRACTICAL NURSES' ASSOCIATION, INC.
Date May 5-9, 1969
Place Robert Lee Motel, New Albany

INDIANA STATE NURSES ASSOCIATION
Date October 16-18, 1969
Place Civic Auditorium, Evansville

Apologia

Three errors in the June, 1968, Roster of Members have been called to our attention. The correct addresses for the following physicians are:

Clark, Edward E. .....19 W. 22nd St., Indianapolis 46202

Clark, George A. .....822 Hume Mansur Bldg., Indianapolis 46204

Tofaute, John L. .....3421 S. Lafountain St., Suite 5, Kokomo 46901

FUTURE MEETINGS, SEMINARS, COURSES

Congress on Medical and Related Aspects of Traffic Accidents

The Third Triennial Congress on Medical and Related Aspects of Traffic Accidents will be held in New York City next year on May 29 to June 1, at the Americana Hotel. It will be devoted to the medical aspects of motor vehicle accidents.

Dr. Milton Helpern, Chief Medical Examiner of the city of New York, is president of the International Association for Accident and Traffic Medicine which will sponsor the meeting.

The International Conference on Drug Abuse will meet at the Americana on June 2, and The International Conference on Poison Control will meet in the same hotel on June 3 and 4. For details of registration, fees and program planning write Secretariat, International Association for Accident and Traffic Medicine, 520 First Ave., New York City 10016.

Rose Polytechnic Institute Offers Fifth Bioengineering Symposium

Rose Polytechnic Institute will be conducting its fifth Bioengineering Symposium on October 21 and 22. Previous meetings were held in 1953, 1956, 1964 and 1966.

Rose Poly is the only college or university in the U. S. which gives an undergraduate degree in biological engineering. The first three B.S. degrees were granted this year. A 20-member graduating class in bioengineering is expected by 1970.

28th Annual AMA Congress on Occupational Health in New York

The 28th Annual AMA Congress on Occupational Health will be held in New York City at the Waldorf-Astoria on September 30 and October 1. There is no registration fee.

The program is acceptable for 11 elective hours by the American Academy of General Practice. A block of rooms is reserved; reservations may be obtained directly with the hotel.

Doctors and **Nurses**

White Conductive Shoes for surgery
—Nurses & Doctors shoes for all occasions
—ORTHOPEDIC shoes for
Men-Women-Children

Shoe Prescription Service by Heidenreich & Son

Heid's

HEALTH SHOE SERVICE
411 N. ILLINOIS
DRIVE-IN PARKING

AFNB—Midwest Charge
ME5-4247

Postgraduate Course in Laryngology, Bronchoesophagology

The Department of Otolaryngology of the Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, will conduct a postgraduate course in Laryngology and Bronchoesophagology from September 23 through October 4. This course is limited to fifteen physicians and will be under the direction of Paul H. Holinger, M.D. It will be held largely at the new Illinois Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, and will include visits to a number of Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in brochoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants will please write directly to the Department of Otolaryngology, College of Medicine, University of Illinois at the Medical Center, Postoffice Box 6998, Chicago, Illinois 60680.

AMA Sponsors 10th Conference On The Medical Aspects of Sports

The Tenth National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association under the auspices of its Committee on the Medical Aspects of Sports, will be held in Miami Beach, Florida, at the Hotel Deauville on December 1. The Conference is held annually in conjunction with and on the first day of the Clinical Convention of the American Medical Association.

The conference is open to key nonmedical athletic personnel as well as interested physicians. Those who would like to receive further information concerning the conference should address the Committee on the Medical Aspects of Sports, American Medical Association, 535 N. Dearborn St., Chicago, Illinois 60610.

Postgraduate Medical Courses In Care of Spinal Cord Injuries

The second of a series of postgraduate medical courses in the care of spinal cord injury patients will be offered to 30 selected physicians at West Roxbury, Mass., October 21 through 25. The course is conducted by the VA.

A similar series of courses is conducted at Long Beach, California. To apply for the course write Veterans Administration, Chief of the Spinal Cord Injury Staff, 810 Vermont Ave., N.W., Washington, D.C. 20420.

Fifth Annual Postgraduate Hospital Medical Staff Conference

The Fifth Annual Postgraduate Hospital Medical Staff Conference will be held at the YMCA Conference Center, Estes Park, Colorado on September 30 to October 4. It will be conducted by the University of Colorado School of Medicine.

The tuition fee for the five days is $85.00. The conference is designed for staff leaders of community hospitals to provide a better understanding of their duties, responsibilities and opportunities. For detailed program and information on housing write the School at 4200 E. Ninth Ave., Denver 80220. ◄

Deaths

Samuel L. Adair, M.D.

Dr. Samuel L. Adair, 59, health officer of Clark County since 1957, died June 8 in Kentucky.

Dr. Adair, who had been ill for several years, was graduated from the University of Louisville in 1933. He was a retired colonel in the Air Force Reserve and served from 1942 until 1946 on active duty in the Air Force. He was on the staffs of the Clark County Memorial Hospital and several Louisville hospitals and was a member of the Clark County Medical Society.

Ivan E. Carlyle, M.D.

Dr. Ivan E. Carlyle, Clinton county physician for 45 years, died June 19 at the age of 87.

Dr. Carlyle was graduated from the University of Louisville in 1908. He practiced at Sedalia for 20 years before moving his office to Michigantown 25 years ago. On the staff of St. Joseph Hospital, Kokomo, Dr. Carlyle was a member of the 50-Year Club, a Senior Member of ISMA and a member of the Clinton County Medical Society.

Melvyn J. Kielton, M.D.

Dr. Melvyn J. Kielton, 32-year-old Elkhart physician, died June 5 as the result of injuries suffered in an auto accident.

Graduated from the I.U. School of Medicine in 1960, Dr. Kielton interned for one year at South Bend's St. Joseph Hospital before moving to Elkhart in 1961. He was a member of the Elkhart County Medical Society.

Desmond F. McGuire, M.D.

Dr. Desmond F. McGuire, Senior Member and member of the ISMA 50-Year Club, died June 12. He was 79.

Dr. McGuire started his practice in Indiana Harbor in 1914 after being graduated from the University of Illinois School of Medicine the year before. He enlisted in the Armed Services in 1917 and served in England and France during World War I. He returned to Indiana Harbor in 1920 and practiced until his retirement in 1966. He was a member of the Lake County Medical Society.

Earl D. Skeen, M.D.

Dr. Earl D. Skeen, 83, died May 30 in South Bend after an illness of six months.

Dr. Skeen went to Gary in 1912, four years after he was graduated from the University of Nebraska Medical School. He practiced there until 1955, when ill health forced him to move from the city to South Bend. He was a member of the Lake County Medical Society, a Senior Member of ISMA and a member of the 50-Year Club.

H. R. Wilber, M.D.

Dr. H. R. Wilber, 66, former Jeffersonville resident, died May 29 in Lebanon, Ky.

A former member of the Clark County Medical Society, Dr. Wilber was a surgeon in Jeffersonville for about 15 years before he retired in 1950 and moved to Florida. ◄

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

INDIANAPOLIS OFFICE:

Kenneth W. Moeller and Phillip P. Capasso, Representatives

665 East 61st Street Telephone: (Area Code 317) 255-6525

Mailing Address: P.O. Box 20132, Indianapolis 46220

Association News

EXECUTIVE COMMITTEE

May 18, 1968

Present: Ralph V. Everly, M.D., chairman, Burton E. Kintner, M.D., G. O. Larson, M.D., P. J. V. Corcoran, M.D., Lowell H. Steen, M.D., Lester H. Hoyt, M.D., Malcolm O. Scamahorn, M.D.

Frank B. Ramsey, M.D., editor of *The Journal*, Robert E. Robinson, attorney, Kenneth W. Bush, administrative assistant, James A. Waggener, executive secretary.

Membership Report:

Full dues paying	3,822
Interns and residents	94
AMA full dues paying	3,683
Full dues paying as of April 30, 1967	3,789
Interns and residents as of April 30, 1967	96

Headquarters Office

The secretary asked for instructions concerning the operation of the headquarters hospitality room at the AMA meeting in San Francisco. On motion of Drs. Steen and Larson, the room is to remain open from 5:00—7:00 p.m. daily for guests, and Doctor Steen is to make the assignments for those who are to be in the room as hosts for the various days.

The secretary reported to the committee on the previous request to investigate an appropriate seal for the association. He presented the seal used by the Indiana State Medical Society, predecessor of the Indiana State Medical Association, which appeared in the transactions of the late 1800's, also the portion of the Constitution and Bylaws providing for this particular seal. He further reported that in tracing the transactions of the association up through 1927, he had been unable to locate the reason why the original seal had been discontinued. On motion of Drs. Larson and Steen, the secretary was instructed to have art work prepared, using the format of the old seal and making the appropriate wording changes. Also the motion included a recommendation that the Constitution and Bylaws Committee prepare an appropriate amendment to the bylaws incorporating this as the official seal of the association.

Treasurer's Office

The treasurer reported on fund balances and the investment account. On motion of Drs. Larson and Kintner, the treasurer was authorized to transfer $5,000 from the general fund to the medical defense account and to replace $5,000 in the general fund investment account from the medical defense investment account. This is necessary due to the lack of available funds in the medical defense account.

The treasurer reported on his discussion with the investment counselor concerning other means of investing association funds. This matter was taken under advisement by the committee for further study.

Unfinished Business

The secretary read his letter to the Board of Trustees of the AMA and their reply concerning what action had been taken on Indiana's resolution No. 13 presented at the Houston meeting.

Organization Matters

Membership in the U.S. Chamber of Commerce, in the amount of $50.00, was approved on motion of Drs. Corcoran and Kintner.

Dr. Corcoran had forwarded a letter with additional information concerning the use and training of medical specialists as aides and this matter and the future development of this type of activity was discussed thoroughly. On motion of Drs. Larson and Corcoran, this matter is to be referred to the Commission on Medical Education with the request that they make a thorough investigation and study of what future developments may be in this particular field. Also the study should include whether these people should be licensed, certified, or what type of recognition would be appropriate.

A letter from Dr. George C. Manning of Fort Wayne was read for the information of the committee.

A letter referred to the association by Sister Juliana of St. Mary's Hospital in Evansville was reviewed and on motion of Drs. Steen and Corcoran, Dr. Corcoran is to discuss this with Sister Juliana and give her the recommendation of the association.

A complaint was read from a physician concerning the new birth certificate and on motion of Drs. Steen and Larson, this is to be referred to the Commission on Public Health for investigation and report.

A letter from the Indiana Interagency Council on Smoking and Health requesting a contribution was taken under advisement.

The minutes of the recent meeting of the Blue Shield Board of Directors was reviewed for the information of the committee.

Dr. Larson then read a letter which he had written to the Blue Shield Board and the letter was approved on motion of Drs. Steen and Corcoran.

The excerpts from the Congressional Record of May 3rd concerning Wilbur Cohen's nomination to be Secretary of HEW was reviewed for the information of the committee.

A report was given to the committee on the responses to the March 30-31 County Society Officers in Comprehensive Health Planning meeting.

A letter from the president of the Indiana State Nurses Association was deferred at the request of the State Nurses Association.

Annual Convention

The secretary reported on the arrangements he had made for the Council dinner and explained that the facilities originally scheduled did not lend themselves well to formal affairs. By consent it was agreed that the officers would discuss this with the Convention Arrangements chairman and ask for recommendations of another location for this dinner.

AMA Meeting

The secretary asked if there were any resolutions to be presented at the AMA meeting and also reviewed the report of the board of trustees concerning nominations and other matters. This material was all referred to the AMA delegates and alternate delegates.

The Journal

Editor of *The Journal*, Dr. Ramsey, who is also president of the SMJAB reported on the growth of the bureau and the increase of Indiana's advertising in *The Journal*.

Future Meetings

The various meetings at the AMA in San Francisco were reviewed, including the I.U. Alumni program.

An invitation to send a representative to the AMA meeting on Air Pollution to be held in Denver July 22-24 was reviewed and no representative is to be sent.

On motion of Drs. Steen and Larson, a letter from the U.S. Public Health Service survey concerning a proposed study in two counties was referred to the president of the Lake County Medical Society.

There being no further business, the committee adjourned to meet again at 4:00 p.m. on Saturday, June 8, 1968, in the headquarters building.

EXECUTIVE COMMITTEE

June 8, 1968

Meeting called to order at 4:00 p.m. In the absence of the chairman, the president, Dr. G.O. Larson, took the chair.

Those responding to roll call were: Burton E. Kinter, M.D., G. O. Larson, M.D., P.J.V. Corcoran, M.D., Lowell H. Steen, M.D., Lester Hoyt, M.D., Malcolm O. Scamahorn, M.D. and James A. Waggener, executive secretary.

Membership Report:

Full dues paying as of May 31, 1968	3,859
Interns and residents as of May 31, 1968	98
AMA full dues paying	3,708
Full dues paying as of May 31, 1967	3,818
Interns and residents as of May 31, 1967	97

Headquarters Office

The secretary informed the committee that the Indiana National Bank reported that the roof of the property at 3920 N. Pennsylvania St. was past repair and gave two quotations for replacing the roof, one of $330.00 and one of $657.00. On motion of Drs. Steen and Hoyt, the secretary was instructed to inform the bank to proceed with re-roofing the property and to give the contract to the Pope Roofing Company at a price of $330.00.

Treasurer's Report

The treasurer's report was approved by consent. The treasurer discussed the investment of funds of the association and on motion of Drs. Hoyt and Steen, the treasurer is authorized to invest $25,000.00 in the Johnston Mutual Fund, 230 Park Ave., New York, as of July 1, 1968.

Unfinished Business

The secretary presented a revised drawing of the original seal of the association and he is instructed to investigate a redesign of this and present it again to the committee.

The secretary reported on the matters which had been referred to the Lake County Medical Society, to the president and to Dr. Shapiro on May 21st and advised no reply had been received.

Organization Matters

An excerpt from the Blue Shield News was read, stating the Minnesota Blue Shield Plan was offering to people of their state a complete comprehensive program covering everything that is not covered by the Medicare law.

As a matter of information, the secretary read a letter from Dr. Sheeley in reply to an inquiry from this office concerning the use of foreign physicians in state institutions.

The report of the Commission on Medical Education and Licensure recommending the association give its approval to I.V. Tech was referred to the Council on motion of Dr. Steen and taken by consent.

An inquiry from the Michigan State Medical Society concerning the functions of a composite state licensure board was read and Dr. Scamahorn is to assist the secretary in formulating a reply.

Several actions of the California Medical Association concerning organ transplants, etc., were reviewed and by consent this matter is to be referred to the Council Liaison Committee with the Medical School.

A letter from Dr. Middleton, chairman of the Commission on Public Health, requesting association cooperation in contiuation of the measles program was reviewed and on motion of Drs. Steen and Scamahorn, the continuation of this program was temporarily approved pending action of the Council on August 19.

A letter from Dr. Middleton requesting representation of a physician on a planning conference to establish a Hospital Pharmacy Service to be held this fall was read and on motion of Dr. Steen and taken by consent, Dr. Schauwecker is to be the representative on the planning committee.

A memo from the AMA reporting on activities of the various states in Comprehensive Health Planning was reviewed for the information of the committee.

Correspondence from Mr. Hollowell concerning emergency room service was reviewed and by consent this is to be referred to the Council Committee on Emergency Medical Service.

Comments received from Dr. Tom Conway were reviewed for the information of the committee.

A notice of a meeting to be held with the I.U. School of Medicine on June 14 to discuss the Medical Television Network was reviewed and by consent Dr. Peter Petrich is to be requested to attend this meeting.

A note from the Better Business Bureau concerning the Consumer Federation of America and the organization of an Indiana Consumer Association was reviewed for the information of the committee.

A request for the use of the mailing list by Dr. Neill Garber, chairman of the Medical Advisory Commission to the Bureau of Motor Vehicles was approved on motion of Drs. Hoyt and Steen.

Annual Convention, Fort Wayne, October 15-18, 1968

On motion of Drs. Hoyt and Kintner, the association will sponsor an Art and Hobby Show at the Fort Wayne convention.

The program for the annual convention was reviewed and Dr. Larson will discuss with the auxiliary the woman's entertainment program.

AMA Meeting

A notice of a meeting of the Committee on Aging of the AMA to be held in San Francisco on June 20 was reviewed and Dr. Steen volunteered to attempt to attend this meeting.

A memo from the AMA concerning programs at San Francisco was reviewed for the information of the committee.

A letter from the AMA concerning vacancies on various AMA councils and committees was reviewed and this was deferred to the August committee meeting.

New Business

A discussion was held concerning the practice of insurance carriers on coordination of benefits and the committee felt that this should be studied as to the legality of this practice. By consent this matter was referred to the Commission on Medical Economics and Insurance for study.

The Journal

The annual report of the president of the SMJAB, Dr. Ramsey, was read for the information of the committee.

Future Meetings

A notice of the meeting of the AMA National Congress on Quackery, to be held in Chicago on October 2-3 and a Conference on Medical Ethics to be held October 4-5 was deferred to the August 19 meeting.

There being no further business, the committee adjourned to meet again at 2:00 p.m. Saturday, July 20, 1968.

THE COUNCIL

June 9, 1968

The Council of the Indiana State Medical Association convened for its June meeting at 10:00 a.m., Sunday, June 9, 1968 in the headquarters office, 3935 North Meridian Street, Indianapolis, with Dr. Lowell H. Steen, the chairman, presiding.

Roll call showed the following present:

Councilors:

First District—Gilbert M. Wilhelmus, Evansville
Second District—Joe Dukes, Dugger
Third District—Elmer L. Wallace, New Albany, alternate
Fourth District—Jack E. Shields, Brownstown, alternate
Fifth District—Wilbert McIntosh, Riley; Cleon M. Schauwecker, Greencastle, alternate
Sixth District—Stephen D. Smith, Knightstown
Seventh District—John O. Butler, Indianapolis, alternate
Eighth District—Paul Sparks, Winchester, alternate
Ninth District—Peter R. Petrich, Attica
Tenth District—Lowell H. Steen, Hammond
Eleventh District—Lowell J. Hillis, Logansport; James A. Harshman, Kokomo, alternate
Twelfth District—William R. Clark, Ft. Wayne
Thirteenth District—George B. Gattman, Elkhart, alternate

Officers:

G. O. Larson, LaPorte, president
Lester H. Hoyt, Indianapolis, treasurer
Malcolm O. Scamahorn, Pittsboro, assistant treasurer

Executive Committee:

Ralph V. Everly, Indianapolis, chairman
Burton E. Kintner, Elkhart, member

Guests:

Lester D. Bibler, M.D., Indianapolis, AMA Trustee

AMA delegates and alternate delegates present:

Eugene F. Senseny, Ft. Wayne
Guy A. Owsley, Hartford City
Jack E. Shields, Brownstown
Kenneth O. Neumann, Lafayette

Staff:

James A. Waggener, executive secretary
Kenneth W. Bush, administrative assistant
Howard Grindstaff, field secretary

The following were absent:

Councilors:

Second District—Betty Dukes, Dugger, alternate
Third District—Donald M. Kerr, Bedford
Fourth District—Robert M. Reid, Columbus
Sixth District—Frank Green, Rushville, alternate
Seventh District—Albert M. Donato, Indianapolis
Eighth District—Donald R. Taylor, Muncie
Ninth District—Clarence Kern, Lebanon, alternate
Tenth District—Herman Wing, Gary
Twelfth District—Frederic L. Schoen, Ft. Wayne
Thirteenth District—Otis R. Bowen, Bremen

Officers:

P. J. V. Corcoran, president-elect

Journal:

Frank B. Ramsey, Indianapolis, editor

AMA delegates and alternate delegates:

Harold C. Ochsner, Indianapolis
Frank Green, Rushville
Donald E. Wood, Indianapolis
Robert M. Brown, Marion
Maurice E. Glock, Ft. Wayne
Dwight W. Schuster, Indianapolis

The Council meeting was held for the purpose of reviewing with the delegates to the AMA matters to come before the AMA meeting in San Francisco. Dr. Gilbert M. Wilhelmus reviewed pages 465 through 474 of the Delegates Handbook which covered: the financial statement of the AMA; Report B of the Board of Trustees concerning Considerations for Coping with the New Climate Involving Health Care; Report C of the Board of Trustees concerning the AMA Posture on Public Comment and Report D of the Board of Trustees concerning Establishment of the Health Council on Manpower. On motion of Drs. Wilhelmus and McIntosh, these reports were accepted.

Dr. Joe Dukes reviewed pages 475 through 485 of the Handbook which covered: Report E of the Board of Trustees which called for the change in the Committee on Blood to Council status and by consent the Council disapproved of this suggested change; Report F of the Board of Trustees on the subject of Osteopathy, a report stating the osteopathic group was not interested in cooperating with the AMA in changing over their schools to medical schools, was approved on motion by Dr. Eugene Senseny and taken by consent; Report G of the Board of Trustees dealing with Guidelines for Payment to Supervising Physicians under PL 89-97 was approved by consent; Report H of the Board of Trustees dealing with Indiana's Resolution 14 calling for a National Conference on Comprehensive Health Planning, in which the Board points out this could better be done at the state level, was approved by consent; The Council voted to take no position on Report I of the Board of Trustees concerning a Study of Federal Health Programs, on motion of Dr. G. O. Larson; Report J of the Board of Trustees dealing with Communications with Boards of Trustees in Hospitals, by consent, was not approved; Report K of the Board of Trustees on Malpractice Insurance and Professional Liability was approved by consent.

Dr. Elmer L. Wallace, alternate councilor, reported on pages 486 through 490 of the Handbook, the first being Report L of the Board of Trustees on Malpractice: More Claims, Higher Awards. By consent this report was accepted; Report M of the Board of Trustees dealing with Action on Interstate Commerce was previously reported to the members of the Indiana State Medical Association and the report was adopted by consent; Report N of the Board of Trustees recommending the plan to call a Conference of County Society Leaders in August—the delegates were urged to support this report; Report O of the Board of Trustees on AMA Educational Conferences for State Legislators was approved by consent; Report P of the Board of Trustees on AMA Central Agency on State Adopted Resolutions, was approved by consent; Report Q of the Board of Trustees, concerning Registration Fee for Non-Member Physicians, which states the Board of Trustees recommends that no change be made in policy—was approved by consent; Report R of the Board of Trustees recommending a change in the name of the Section on Miscellaneous Topics to "Section on Special Topics" was approved by consent.

Dr. Jack E. Shields, alternate councilor and AMA delegate, reported on pages 497 through 509 which included: Report S of the Board of Trustees on Medical Disabilities Impairing Driver Ability. No action was taken on this report; Report T of the Board of Trustees concerning Slow Moving Vehicle (SMV) Emblem, report was taken for information; Report U of the Board of Trustees concerning the Bicentennial Celebration of the Declaration of Independence, which was a result of Resolution 9 introduced at the Clinical Session in 1967 and calling for the AMA to build a building in Philadelphia, the report recommends not constructing such

a building. By consent this report was approved; Report V of the Board of Trustees concerning the Fourth National Congress on Health Quackery—the Council approved the holding of this Congress and instructed the delegates that representatives of the Government be included and letters sent inviting them to attend. This action was taken on motion of Drs. Steen and Larson; Report W of the Board of Trustees concerning the Interagency Council on Smoking and Health was accepted for information; Report X of the Board of Trustees was a Report on Graduate Medical Education and this report was accepted for information; Report Y of the Board of Trustees concerning the AMA Statement on Infant Mortality in the United States was adopted and the Council urged that this same report be referred to the House of Delegates of the Indiana State Medical Association at the Fort Wayne meeting.

Dr. Cleon M. Schauwecker reviewed pages 510 through 521 of the Handbook, the first being Report Z of the Board of Trustees, subject: Report of Committee on Health Care Financing. The Council, by consent, adopted this as a matter of information and recommended to the delegates that they work to keep from having this report scuttled and suggested it might be referred to the AMA Council on Medical Services.

Dr. Stephen D. Smith reviewed pages 522 through 529 of the Handbook, the first being Report AA of the Board of Trustees concerning Financial Status of the AMA. This was taken as a matter of information; Report BB of the Board of Trustees, subject: Nominations for Council on Constitution and Bylaws. This matter was left to the judgment of the delegates as was Report CC of the Board of Trustees concerning Nominations for Council on Medical Education and Report DD on Nominations for Council on Medical Service; Report A of the Council on Constitution and Bylaws concerning the Change of Name of Section on Laryngology, Otology and Rhinology to the Section on Otorhinolaryngology, was accepted as a matter of information; Report B of the Council on Constitution and Bylaws recommending a change in the name of the Section on Miscellaneous Topics to Section on Special Topics was accepted by the Council; Report C of the Council on Constitution and Bylaws concerning the right of the vice president to vote at meetings of the Board of Trustees—delegates were instructed it was the desire of the Council that the change be made to allow the vice president a vote on the Board. This was taken by consent.

Dr. John O. Butler reported on pages 530 through 538 of the Handbook, the first being Report D of the Council on Constitution and Bylaws setting forth the Procedure for Introduction and Consideration of Resolutions and Other Business of the AMA House of Delegates. The Council accepted this report calling attention of the delegates to the fact that the change should also provide that a majority of the delegates must be present whenever a vote is taken; Report E of the Council on Constitution and Bylaws set forth the mechanics for Withdrawal of Resolutions. This report was approved by consent; Report F of the Council on Constitution and Bylaws concerning the Terms of Office of the President and Vice President was approved by consent; Report G of the Council on Constitution and Bylaws clarified ex officio members of the House of Delegates and this report was approved by consent.

Dr. Paul Sparks reviewed pages 539 through 554, the first being Report A of the Council on Medical Education and this report was accepted by consent; Report B of the Council on Medical Education concerning Revision of "Essentials of Approved Residencies" Pertaining to Residencies in Physical Medicine and Rehabilitation was accepted by the Council; Report C of the Council on Medical Education dealing with Revision of "Essentials of Approved Residencies" Pertaining to Residencies in Psychiatry was accepted by consent; Report D of the Council on Medical Education concerning revision of "Essentials of Approved Residencies" Pertaining to Residencies in Anesthesiology, no action was taken on this report pending developments which the delegates anticipate will take place in San Francisco. Final decision on this report is left in the hands of the delegates; Report A of the Council on Medical Service concerning Medical Society Participation in Government Medical Care Programs was accepted by consent.

Dr. Peter R. Petrich reviewed pages 555 through 566 of the Handbook, the first being report of the Ad Hoc Committee to Study the Modus Operandi of the Scientific Sections. On motion of Drs. Larson and Steen, the Council voted to oppose this recommendation and to retain the status quo of the sections as they currently exist.

Dr. Lowell H. Steen reviewed pages 567 through 582, the first being Resolution 1, Subject: Standard Wearing Place for the Emergency Medical Identification Symbol. It was approved by consent; Resolution 2, Subject: Drug Abuse. The delegates were instructed to oppose this resolution. It was felt that it was not necessary; Resolution 3, Subject: Disability and/or Illness Insurance for Volunteer Physicians Serving in Vietnam, approved by consent; Resolution 4, Subject: Environmental Quality, approved by consent; Resolution 5, Subject: Obituary Notices in *The Journal of The American Medical Association*— by consent it was agreed that this resolution should be opposed; Resolution 6, Subject: Air Pollution, approved by consent; Resolution 7, Subject: Schools of Medical Technology, approved by consent; Resolution 8, Subject: National Study Committee on Organ Transplants, approved by consent; Resolution 9, Subject: Subsidizing Medical Groups, the delegates were instructed to attempt to amend this resolution by inserting between the words "group medical" in line two in the first Whereas, the following words: "closed panel with capitation tax" and also to amend the resolve in line 11 by inserting between the words "subsidizing" and "group" the words "closed panel with capitation tax." The delegates were further instructed that this resolution could be supported if amended and if not successfully amended, it should be opposed; Resolution 10, Subject: Medicare "Explanation of Benefits" Form. The Council instructed the delegates to attempt to amend this resolution by amending the resolve in line 13 by inserting after the word "Administration" and before the word "to" the following: "Blue Shield and other fiscal intermediaries;" Resolution 11, Subject: Payment to Physicians for Portable X-Ray Service in Extended Care Facilities, approved by consent; Resolution 12, Subject: Changes in Public Law 89-97—Recertification, approved by consent; Resolution 13, Subject: Changes in Public Law 89-97—Direct Billing, approved by consent; Resolution 14, Subject: Treatment of Obesity, approved by consent; Resolution 15, Subject: Social Economic Research, approved by consent.

Dr. Lowell J. Hillis reviewed pages 583 through 598 of the Handbook, the first being Resolution 16, dealing with Public Law 89-749 which was approved by consent; Resolution 17, Subject: Financial Economics, approved by consent; Resolution 18, Subject: Health Insurance for the "Medically Needy", approved by consent; Resolution 19, Payment of Medicare Benefits, approved by consent; Resolution 20, Revised Certificate of Live Birth, approved by consent; Resolution 21, Subject: Misinformation Promulgated by the Department of Health, Education and Welfare regarding the Practice of Laboratory Medicine, approved by consent; Resolution 22, Definition of "The Related Healing Arts," approved by consent; Resolution 23 Health Care Costs—the delegates were instructed to attempt to amend this resolution by the deletion of the fourth Where

in lines 11 through 13, otherwise approved by consent; Resolution 24, AMA Membership, approved by consent; Resolution 25, Double Standards for United States Citizens who have received Degrees, Doctor of Medicine, from Foreign Universities, versus those Graduating from United States Schools of Medicine. By consent this resolution was to be opposed; Resolution 26, Amendments to the "Guidelines for Establishing Medical Society Review Committees", approved by consent.

Dr. William Clark reviewed pages 600 through 614 of the Handbook, the first being Resolution 27, Supervision of AMA Councils and Committees by the Board of Trustees, approved by consent; Resolution 28, Forum on Solo Practice, approved by consent; Resolution 29, Group Practice, approved by consent; Resolution 30, Second National Congress on Socio-Economics of Health Care, taken for information only; Resolution 31, AMA Spokesman, approved by consent; Resolution 32, Participation of Osteopathic Physicians in AMA Approved Internship and Residency Programs, approved by consent; Resolution 33, Insurance Coverage for Ambulatory Prehospitalization Workup, taken as a matter of information; Resolution 34, Joint Commission on Accreditation of Schools of Nursing—this resolution to be opposed; Resolution 35, Financial Support by the U.S. Department of Transportation for Research, Production, and Testing of the "New York State Safety Sedan"—this resolution is to be opposed; Resolution 36, Qualified Advisors, approved by consent; Resolution 37, Non-Medical Controlled Practice of Medicine, approved by consent; Resolution 38, Composition of AMA Council on Medical Education, approved by consent; Resolution 39, Study of Health Data Banking Service, approved by consent.

Dr. George B. Gattman reviewed pages 615 through 625 of the Handbook, the first being Resolution 40, Study of Competitive Factors in Health Services Production, approved by consent; Resolution 41, Reconsideration of Interspecialty Committee Report on "Physician Participation in Organized Medicine," approved by consent; Resolution 42, Certification of Rural Hospitals for Medicare, approved by consent; Resolution 43, Allied Health Professions and Paramedical Personnel, approved by consent; Resolution 44, Public Laws 89-749 and 90-174, approved by consent; Resolution 45, Recertification, approved by consent; Resolution 46, Joint Commission on Accreditation of Hospitals, approved by consent; Resolution 47, Joint Commission on Accreditation of Hospitals, by consent, the delegates were instructed to attempt to amend this resolution to refer this to the Council on Medical Service; Resolution 48, Joint Commission on Accreditation of Hospitals, approved by consent.

This completed a review of the materials available at this time which will come before the AMA meeting of the House of Delegates at the San Francisco meeting.

Other actions taken by the Council in executive session, were as follows: The Council established the rule that the executive session of the Council shall be composed of the elected councilors, the president, president-elect, and treasurer all with the power to vote; also the alternate councilors and the executive secretary, all with the privilege of discussion but not the right to vote.

It was also agreed that all absentees from Council meetings in the future will be so listed in the Council minutes. On motion of Drs. Petrich and Clark, the president was urged to write a letter to all absentees calling attention to the fact that as an office holder in this association they are expected to attend meetings of the association.

Action was also taken to have The IMPAC Board meet with the Council at its meeting on August 18th. By consent it was agreed that the reports of the councilors to the societies in their districts would be deferred and incorporated in the report of the actions taken by the AMA House of Delegates in San Francisco.

It was also agreed that the Council would request the members of the Blue Shield Board to meet with them on August 18th.

There being no further business, the Council adjourned to meet again on August 18-19, 1968.

COMMERCIAL ANNOUNCEMENTS

BUY AND TRY: Wye Plantatian Aberdeen-Angus frozen semen fram Advanced Register P.R.I. sires officially gaining over four pounds per day or whose 365-day weights are above 1,200 pounds. (Performance tested sires always for sale.) WYE PLANTATION, Queenstown, Maryland 21658. Telephones: 301-827-7166 or 301-827-7160.

WANTED TO BUY: Used equipment far dactar's affice — general practice. Please phone 546-7481, Indianapalis.

WANTED: In a college cammunity, an associate ar partner far a large medical practice. Na surgery or OB. General practice can be done if desired. X-ray and laboratory facilities in the office. If desired, will consider sale. Write Bax 344, The Journal, ISMA, 3935 N. Meridian St., Indianapalis, Ind. 46208.

EMERGENCY ROOM PHYSICIAN: Excellent appartunity for young physician interested in full-time practice of emergency raom care. Jain a physician group responsible for the emergency service of two major Cincinnati hospitals. Remuneration an a fee-for-service basis with guaranteed minimum. Must have or be eligible far Ohio license. Send resume to P. O. Box 36163, Cincinnati, Ohia 45236.

SEVENTEEN-MAN Wiscansin group located in callege community af 40,000 with excellent hospital facilities is seeking additional assaciates in the following areas:

1. Internal Medicine
2. Urology
3. General Surgery
4. General Practice

Far further infarmation, please contact D. R. Griffith, M.D., Midelfart Clinic, Eau Claire, Wis. 54701.

OPENING for patholagist, psychiatrist and general practitianer (preferably with psychiatric ar geriatric experience). 1651-bed general medical-surgical and psychiatric haspital with excellent facilities and pragressive staff; an equal appartunity emplayer. Salary: $13,507.00 through $23,921.00 accarding ta training and experience. Write ta Directar, VAH, Danville, Illinais 61832.

NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

Charges for commercial announcements are:

First four lines: $3.00
each additional line: 50¢

Send cash with order. Average count: seven words to the line.

DEADLINE: Fifth day of month PRECEDING month of issue.

ADVERTISERS IN THIS ISSUE

August 1968 Volume 61 No. 8

Abbott Laboratories 1109-13
Associated Credit Bureaus of Indiana .....3rd Cover
Burroughs Wellcome & Co., Inc. 1135
Breon Laboratories, Inc. 1170
Brown Pharmaceutical Co. 1174
Campbell Soup Company 1129
Coca-Cola Company 1158
Dairy Councils of Indiana 1085
Dow Chemical Company, The 1087
Geigy Pharmaceuticals 1094-95
Hanger, J. E., Inc. 1172
Harding Hospital 1172
Heid's Shoe Store 1176
Hynson, Westcott & Dunning, Inc. 1081
Indiana Medical Bureau 1153
Lederle Laboratories 1083, 1165, 1171
Lilly, Eli & Company 1090-91, 1100
Medical Protective Co. of Ft. Wayne 1177
Mutual Medical Insurance, Inc. .....2nd Cover
National Drug Company 1093
Parke, Davis & Company 1092
Poythress, Wm. P. & Co., Inc. 1164
Roche Laboratories .....4th Cover, 1155
Rorer, William H., Inc. 1117, 1173
Sandoz Pharmaceuticals 1132
Searle, G. D. & Co. 1130-31
Stuart Company, The 1089
Wabash Valley Hospital 1106
Warner-Chilcott Laboratories 1167-68
Warren-Teed Pharmaceuticals 1149-50

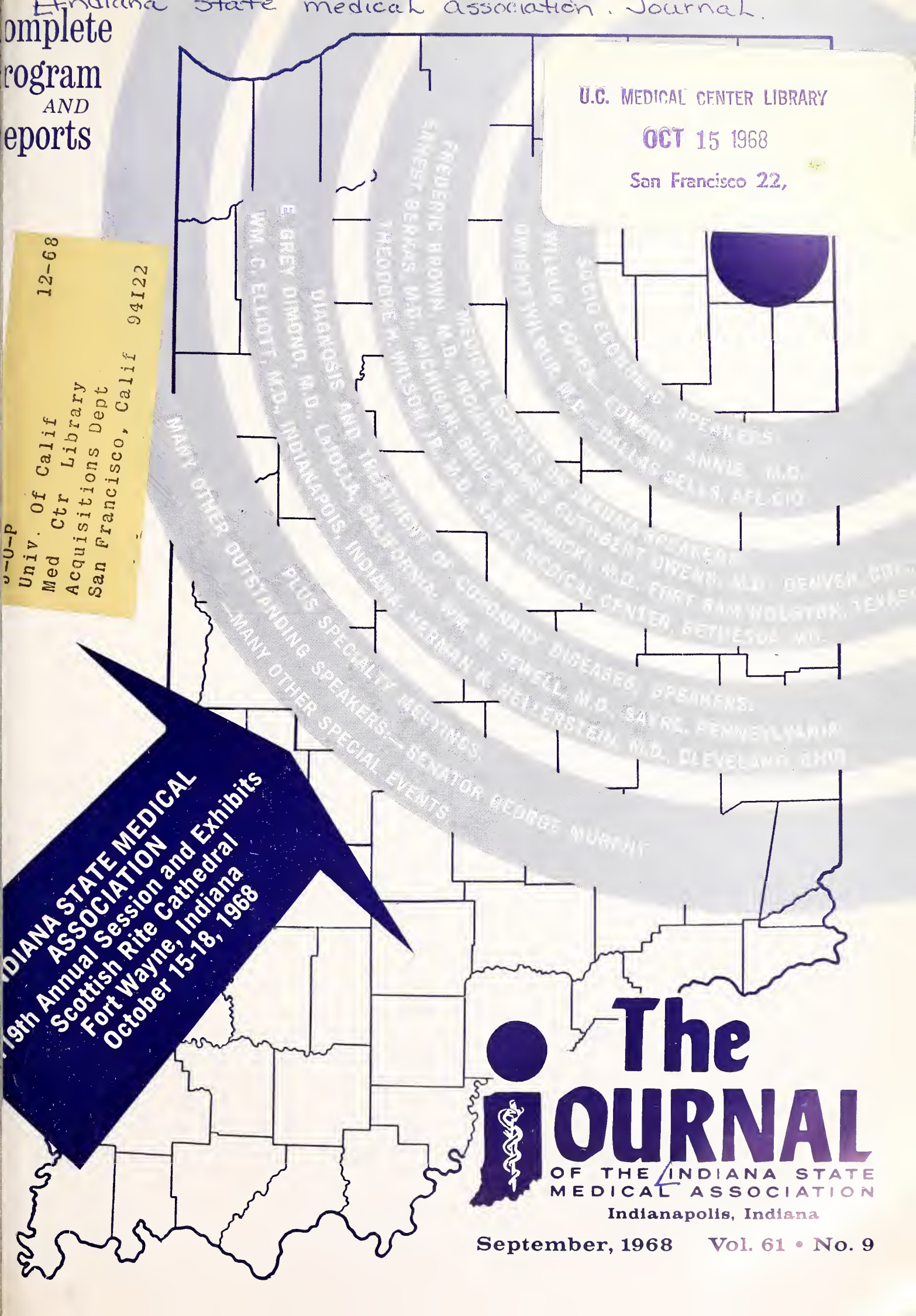
In accepting advertising for publication, *The Journal* has exercised reasonable precaution to insure that only reputable factual advertisements are included. However, we do not have facilities to make any comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services, and medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertiser only. Neither sanction nor endorsement of such is warranted, stated. or implied by the association.

Indiana State Medical Association Journal.

omplete
rogram
AND
eports

U.C. MEDICAL CENTER LIBRARY
OCT 15 1968
San Francisco 22,

Univ. Of Calif
Med Ctr Library
Acquisitions Dept
San Francisco, Calif 94122
12-68
S-U-P



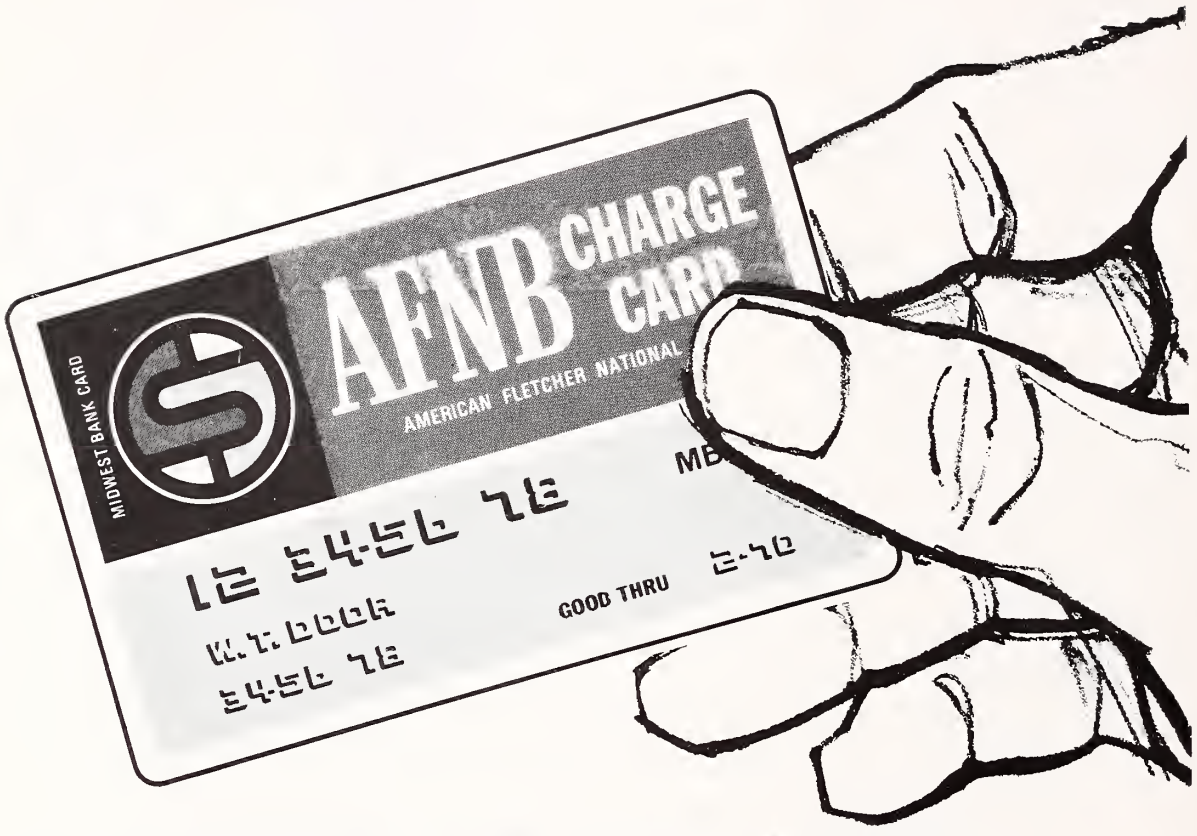
INDIANA STATE MEDICAL ASSOCIATION
119th Annual Session and Exhibits
Scottish Rite Cathedral
Fort Wayne, Indiana
October 15-18, 1968

The JOURNAL

OF THE INDIANA STATE MEDICAL ASSOCIATION

Indianapolis, Indiana

September, 1968 Vol. 61 • No. 9



A CONVENIENCE FOR YOUR PATIENTS
A BLESSING FOR YOU

By offering the AFNB Charge Card service you will provide many of your patients with the most convenient way to pay for your professional services. It will help you, too, by virtually eliminating your billing and collection duties . . . and your account is credited immediately when you deposit the daily charge tickets (which we provide). Simply send the coupon or phone 633-5040 for complete information.

TO: AFNB Charge Card Division
101 Monument Circle
Indianapolis, Indiana 46204

I am interested in your program. You can call at my office on_____ (DATE) at_____ (TIME)

or phone_____ for an appointment.

Name_____

Address_____

serving the professional man in a professional manner.

FULL SERVICE BANK

AFNB

AMERICAN FLETCHER NATIONAL BANK

INDIANAPOLIS, INDIANA MEMBER FEDERAL DEPOSIT INSURANCE CORPORATION

Lutrexin®

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

IN THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF PREMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION

■ LUTREXIN, the non-steroid "uterine relaxing factor" has been found to be useful by many clinicians in controlling abnormal uterine activity.

■ Literature on indications and dosage available on request.

■ No side effects have been reported, even when massive doses (25 tablets per day) were administered.

■ Supplied in bottles of twenty-five 3,000 unit tablets.

(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

HYNSON, WESTCOTT & DUNNING, INC. HW&D BALTIMORE, MARYLAND 21201

(LTR23)

SEPTEMBER 1968

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Office of Publication

3935 N. Meridian, Indianapolis, Indiana 46208

Contents

SCIENTIFIC

The Treatment of Multiple Sclerosis with Intrathecally Administered Methylprednisolone Acetate, William A. Ringer, M.D., Williamsport 1213

An Evaluation of the Psychological Aspects of Dropouts, Robert F. Green, M.D., Fort Wayne 1216

Electrocardiogram of the Month, Charles Fisch, M.D., Indianapolis 1222

X-Ray Conference: Blastomycosis Osteomyelitis, John L. Greer, M.D., Erich K. Lang, M.D., Shreveport, La. 1227

EDITORIALS

The Undiagnosed Diabetic 1230

The Secretary's Misconception 1230

Charge to Interns, Donald E. Stephens, M.D., Indianapolis 1231

FLEX (Guest) 1231

Generic Politicians (Guest) 1232

Editorial Notes 1232

CONVENTION SECTION

Section Begins 1235

Table of Contents to Special Convention Section 1236

Hotel and Motel Reservation Form for ISMA Convention 1287

Art, Hobby Show Application Form 1344

SPECIAL FEATURES

The S.S. HOPE — A Modern Medical Center, Arthur Baptisti, Jr., M.D., Indianapolis 1288

Orient Medical Tour, Wei-Ping Loh, M.D., Gary 1292

The New State Board Examination, Merritt O. Alcorn, M.D., Madison 1300

REGULAR FEATURES

What's New? 1197

Fourth Estate 1200

Month in Washington 1204

From The Journal 50 Years Ago 1228

President's Page 1233

The Woman's Auxiliary Reports to ISMA 1234

Gleaned from the British Medical Journal, Jack W. Hickman, M.D., Indianapolis 1294

Day by Day with the F.D.A. 1302

Medicine At Law 1306

Abstracts, Book Reviews 1311

New Blue Shield National Account ID Card (One of a Series) 1318

Wanted: Physicians, Locations 1324

News Notes 1331

Board of Health Report 1340

Future Meetings, Seminars, Courses 1342

Annual Meeting Dates of Professional Medical and Allied Organizations 1349

Deaths 1350

BUSINESS

Executive Committee: July 20, 1968 1352

Council: May 18 and 19, 1968 1354

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editar and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial baard members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Communicatians dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 46202. All ather communicatians shauld be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapalis 46208.

Advertising rates will be furnished on request. Copy must be received by the 5th af the month preceding month af issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

Representative for national advertising is the State Medical Journal Advertising Bureau, 510 N. Dearborn St., Chicaga, Ill.

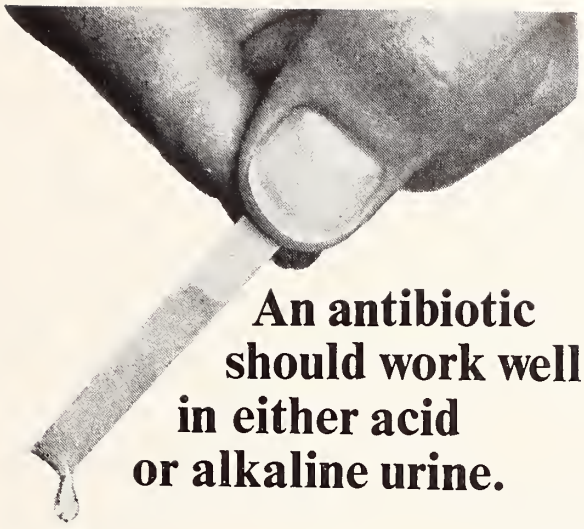
Entered as second class matter January 25, 1933, at the Pastoffice at Indianapolis, Indiana. Capyright, 1968 by the Indiana State Medical Associatian. Published manthly at 3935 N. Meridian, Indianapalis 46208.

Second-class pastage paid at Indianapolis, Indiana and at additianal mailing affice

All issues af 1967 and subsequently may be obtained on microfilm. Address The Journal far details.

About Our Cover

on page 1215.



An antibiotic should work well in either acid or alkaline urine.

It isn't always necessary to adjust urinary pH in treating G.U. infections.

Not when the causative organism is a strain sensitive to DECLOMYCIN® Demethylchlortetracycline, as is often the case.

DECLOMYCIN remains stable and active in either acid or alkaline urine. So there's no need to acidify the urine to keep the antibiotic at work.

Why match the urine to the antibiotic...when you can match the antibiotic to the urine...by prescribing DECLOMYCIN. A b.i.d. dosage makes therapy convenient for your patient.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system – anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin – maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney – rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth – dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; Tablets: film coated – 300 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

355-0

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545

ANNUAL CONVENTION—OCTOBER 15-18, 1968—FORT WAYNE

OFFICERS FOR 1967-68

President—G. O. Larson, M.D., 1110 Indiana Ave., LaPorte 46350.

President-Elect—Patrick J. V. Corcoran, 3700 Bellemeade, Evansville 47715.

Treasurer—Lester H. Hoyt, M.D., Methodist Hospital, Indianapolis 46207.

Assistant Treasurer—Malcolm O. Scamahorn, Pittsboro 46167.

Executive Secretary—Mr. James A. Waggener, 3935 N Meridian, Indianapolis 46208.

COUNCILORS

District	Term Expires
1—Gilbert M. Wilhelmus, Evansville	Oct. 1968
2—Joe Dukes, Dugger	Oct. 1969
3—Donald M. Kerr, Bedford	Oct. 1970
4—Robert M. Reid, Columbus	Oct. 1968
5—Wilbert McIntosh, Riley	Oct. 1969
6—Stephen D. Smith, Knightstown	Oct. 1970
7—Albert M. Donato, Indianapolis	Oct. 1968
8—Donald R. Taylor, Muncie	Oct. 1969
9—Peter R. Petrich, Attica	Oct. 1970
10—Lowell H. Steen, Whiting (Chairman)	Oct. 1968
11—Lowell Hillis, Logansport	Oct. 1969
12—William R. Clark, Fort Wayne	Oct. 1970
13—Otis R. Bowen, Bremen	Oct. 1968

ALTERNATE COUNCILORS

District	Term Expires
1—Eugene Austin, Evansville	1970
2—Betty Dukes, Dugger	1968
3—Elmer L. Wallace, New Albany	1968
4—Jack E. Shields, Brownstown	1970
5—Cleon M. Schauwecker, Greencastle	1970
6—Frank Green, Rushville	1969
7—John O. Butler, Indianapolis	1969
8—Paul Sparks, Winchester	1970
9—Clarence G. Kern, Lebanon	1968
10—Herman Wing, Gary	1969
11—James A. Harshman, Kokomo	1968
12—Frederic L. Schoen, Fort Wayne	1970
13—George B. Gattman, Elkhart	1970

SECTION OFFICERS 1967-68

Section on Surgery:
Chairman—Donald M. Schlegel, Indianapolis
Vice-chairman—Henry Larzelere, Marion
Secretary—Austin Gardner, Indianapolis

Section on Internal Medicine:
Chairman—I. E. Michael, Indianapolis
Vice-chairman—Louis Sandock, South Bend
Secretary—Robert L. Rudesill, Indianapolis

Section on Ophthalmology and Otolaryngology:
Chairman—David E. Brown, Indianapolis
Vice-chairman—Kenneth F. Isenogle, Fort Wayne
Secretary—George A. Clark, Indianapolis

Section on Anesthesiology:
Chairman—William M. Matthews, Indianapolis
Vice-chairman—Merle E. Pickett, Fort Wayne
Secretary—Jerry R. Miller, Indianapolis

Section on General Practice:
Chairman—Jay S. Reese, Martinsville
Vice-chairman—Robert Mouser, Indianapolis
Secretary—Richard Juergens, Fort Wayne

Section on Obstetrics and Gynecology:
Chairman—Robert M. Reid, Columbus
Vice-chairman—Tom W. Wachob, Jr., Kokomo
Secretary—Charles R. Echt, Indianapolis

Section on Public Health and Preventive Medicine:
Chairman—Donald M. Kerr, Bedford
Vice-chairman—T. Neal Petry, Delphi
Secretary—Henry G. Nester, Indianapolis

Section on Radiology:
Chairman—John A. Robb, Indianapolis
Vice-chairman—Robert E. Beck, Evansville
Secretary—Dale B. Parshall, Elkhart

Section on Nervous and Mental Diseases.
Chairman—Gordon T. Brown, Indianapolis
Vice-chairman—James E. Benson, Elkhart
Secretary—Wesley A. Kissel, Indianopolis

Section on Pathology:
Chairman— Robert J. Frost, Michigan City
Vice-chairman—Frank Vellios, Indianapolis
Secretary—Robert L. Costin, Indianapolis

Section on Pediatrics:
Chairman—Roland E. Miller, Lafayette
Vice-chairman—Gustaf W. Erickson, South Bend
Secretory—Morris Green, Indianopolis

DELEGATES TO THE AMA

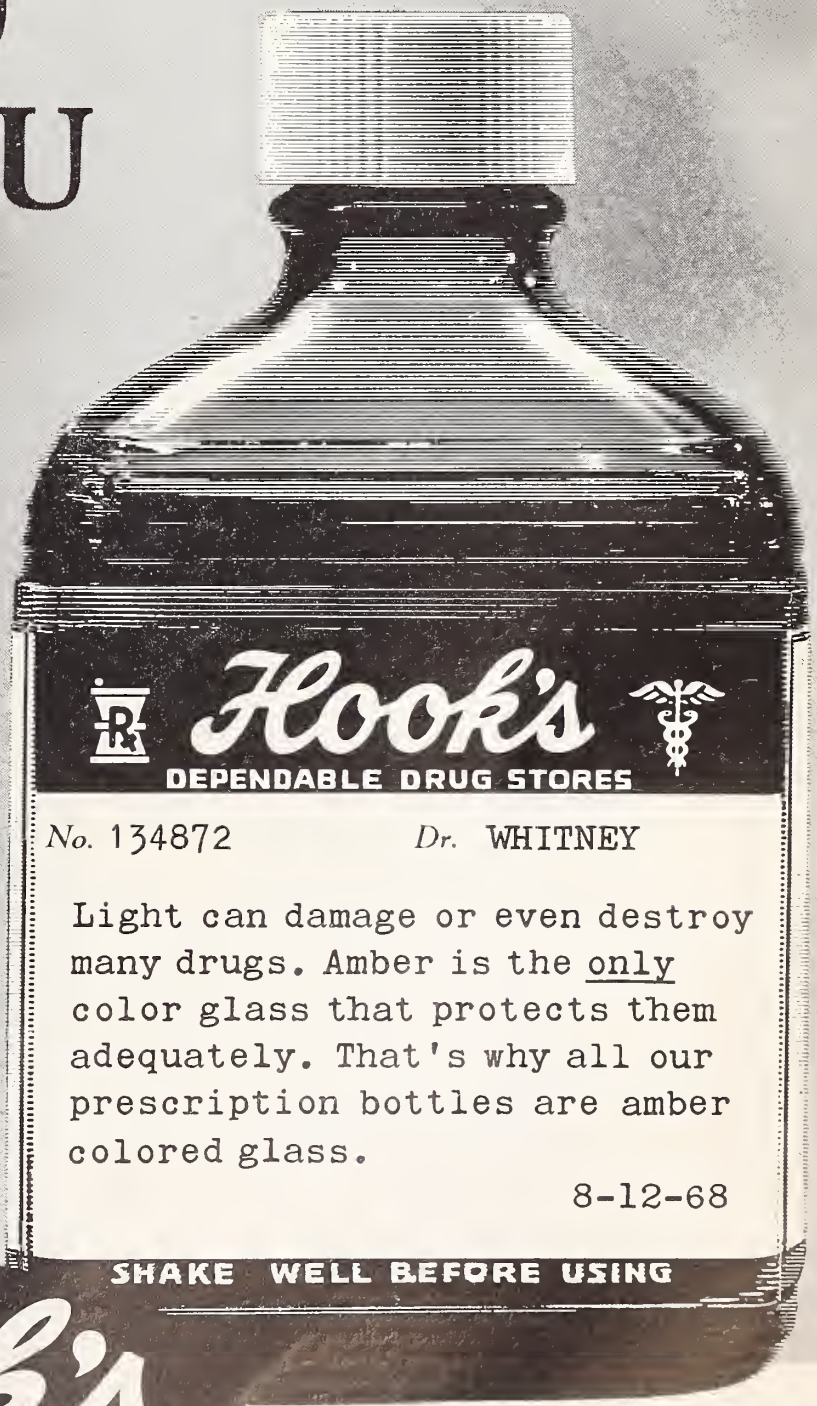
Terms expire December 31, 1968:

Delegates	Alternates
Harold C. Ochsner Indianapolis	Don E. Wood Indianapolis
Eugene F. Senseny Fort Wayne	Robert M. Brown Marion
Frank H. Green Rushville	Kenneth O. Neumonn Lafayette

Terms expire December 31, 1969:

Delegates	Alternates
Guy A. Owsley Hartford City	Maurice E. Glock Fort Wayne
Jack E. Shields Brownstown	Dwight W. Schuster Indionopolis

What's Good for Your PRESCRIPTION is GOOD FOR YOU

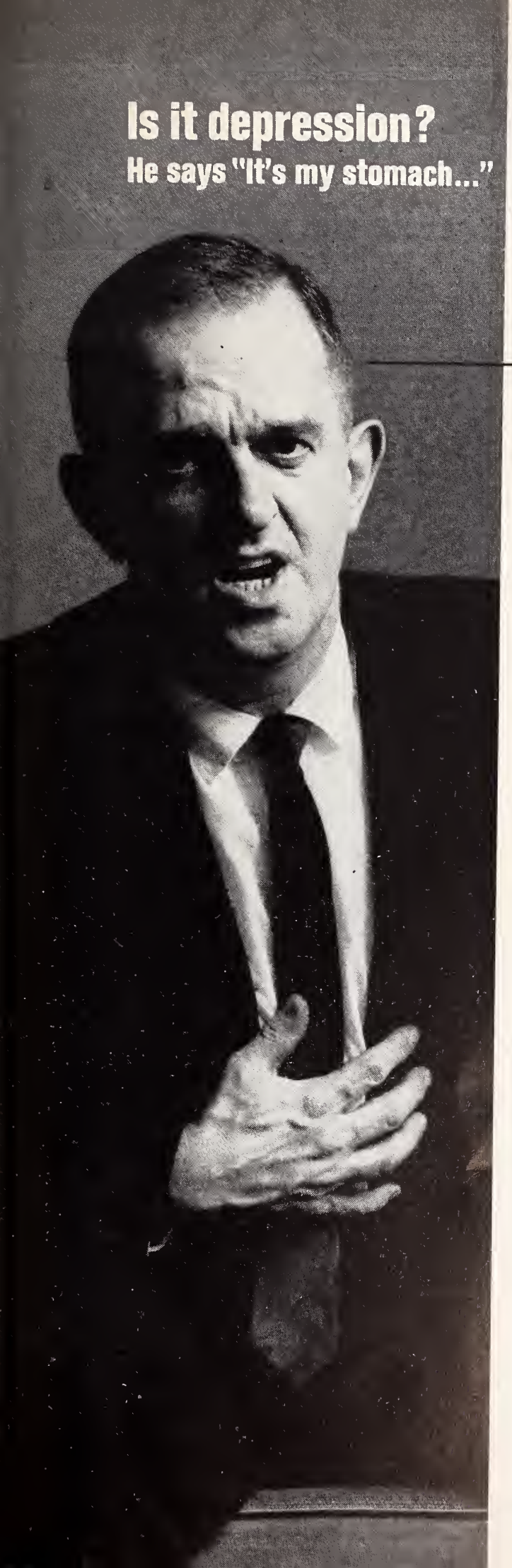


Hook's
DEPENDABLE DRUG STORES

Hook's extra care and low prices may account for the ever growing number of our prescription customers. We believe so! We were trusted over 2½ million times last year; we invite you to compare and save.

COUNTY MEDICAL SOCIETY DIRECTORY

COUNTY	PRESIDENT	SECRETARY
Adams	Arthur H. Girod, Decatur	Harold F. Zwick, 227 S. Second St., Decatur
Allen (Fort Wayne)	Frederic L. Schoen, Fort Wayne	Eugene E. Schmidt, Suite 725, Indiana Bank Bldg., Fort Wayne
		Mr. Larry L. Pickering, Exec. Secy., 212 Med. Ctr. Bldg., Fort Wayne
Bartholomew-Brown	Harold W. Richmond, Columbus	C. David Ryan, 2600 Sandcrest Blvd., Columbus
Benton	A. L. Coddens, Earl Park	D. L. McKinney, Box 398, Otterbein
Boone	James R. McAfee, Lebanon	Katherine A. Jackson, 95 E. Oak St., Zionsville
Carroll	Marilyn L. Wagoner, Burlington	Robert Seese, 101 W. North St., Delphi
Cass	Joseph S. Bean, Logansport	Edward L. TerBush, 216 Ninth Street, Logansport
Clark	Robert K. McKechnie, Jeffersonville	Hassi Shina, Charlestown
Clay	J. Frank Maurer, Brazil	Forrest R. Buell, 314 Lankford St., Clay City
Clinton	Bruce A. Work, Frankfort	George K. Hammersley, 361 E. Clinton St., Frankfort
Daviess-Martin	A. G. Blazey, Washington	Hamlin B. Lindsay, 511 E. Main St., Washington
Dearborn-Ohio	Fred D. Houston, Lawrenceburg	Leslie M. Baker, 501 Fourth St., Aurora
Decatur	Dale D. Dickson, Greensburg	Arnold D. Ducanes, 215 N. Franklin St., Greensburg
DeKalb	John C. Harvey, Auburn	C. Bishop Hathaway, 209 N. Jackson St., Auburn
Delaware-Blackford	Glynn A. Rivers, Muncie	Richard N. Philbert, 2810 Ethel Ave., Muncie
Dubois	John P. Salb, Jasper	Edward Ploetner, 111-115 Central Bldg., Jasper
Elkhart	Philip G. Bowser, Goshen	Page E. Spray, 320 W. High St., Elkhart
Fayette-Franklin	B. W. Sanders, Connersville	J. L. Steinem, 818 Grand Ave., Connersville
Floyd	William F. Ruoff, New Albany	Daniel H. Cannon, 1201 E. Spring St., New Albany
Fountain-Warren	Max N. Hoffman, Covington	Theodore Person, 601 N. Mill St., Veedersburg
Fulton	Joseph D. Richardson, Rochester	F. Richard Walton, 116 W. 9th St., Rochester
Gibson	William E. Dye, Oakland City	David H. Lindauer, 115 N. Prince St., Princeton
Grant	J. C. Jarrett, Marion	Robert G. Young, 1207 Northwood Ct., Marion
Greene	Robert Moses, Worthington	Harry Rotman, Jasonville
Hamilton	John S. Hash, Noblesville	H. R. Blackburn, Riverview Hospital, Noblesville
Hancock	John J. Farrell, Greenfield	Joseph A. Miller, Oaklandon
Harrison-Crawford	Carl Dillman, Corydon	Richard A. Jordan, Corydon
Hendricks	Eli Coats, Indianapolis	Carl J. Heinlein, 637 E. Main, Danville
Henry	John E. Fisher, New Castle	Phyllis Grant, 3007 S. 14th St., New Castle
Howard	Robert L. Michael, Kokomo	J. F. Doss, 3520 Lafountain, Kokomo
Huntington	Barth E. Wheeler, Huntington	Carl S. Ray, Warren
Jackson-Jennings	Kenneth E. Bobb, Seymour	Willlam F. Blaisdell, 207 N. Pine, Seymour
Jasper	Ernest R. Beaver, Rensselaer	Francis E. O'Brien, McKinley and Washington Sts., Rensselaer
Jay	Ralph Steffy, Portland	Elizabeth Tate, 317 S. Main St., Dunkirk
Jefferson-Switzerland	Elton Heaton, Madison	Ott B. McAtee, Madison State Hospital, Madison
Johnson	George Brown, Greenwood	Charles Link, 365 E. Main St., Greenwood
Knox	Boyd K. Black, Vincennes	John S. Murray, 317 Security Bank Bldg., Vincennes
Kosciusko	Wymond B. Wilson, Mentone	Arthur L. Moser, 600 Winona, Warsaw
LaGrange	Michael O. Mellinger, LaGrange	Allen S. Martin, Box 3A, Shipshewana
Lake	Seymour W. Shapiro, Gary	Reginald R. Barton, 7737 Forrest Ave., Gary
		Mr. John B. Twyman, Ex. Dir., 4640 W. 5th Ave., Gary
LaPorte	William E. Wolf, LaPorte	James J. J. Sprecher, 1001 Maple Ave., LaPorte
		Mrs. Polly Dent, Exec. Dir., 903 Indiana Ave., LaPorte
Lawrence	George W. Sorrells, Bedford	Reid C. Crosby, 11 Saddler Ct., Bedford
Madison	John R. Wagoner, Anderson	William M. Stinson, 333 Jackson St., Anderson
Marion	Dwight W. Schuster, Indianapolis	John O. Butler, 234 E. Southern Ave., Indianapolis
		Mr. Arthur G. Loftin, Exec. Secy., 211 N. Delaware St., Indianapolis
Marshall	John K. Guild, Plymouth	M. George Rosero, Kewanna
Miami	Parker W. Snyder, Peru	Gordon S. Crates, Denver
Montgomery	V. G. Viray, Crawfordsville	W. E. Shannon, 408 W. Market St., Crawfordsville
Morgan	George Ostheimer, Martinsville	Maurice A. Turner, 10½ N. Main St., Martinsville
Newton	John Parker, Goodland	Arthur Schoonveld, Brook
Noble	O. Thomas Slough, Kendallville	Joseph Greenlee, Avilla
Orange	Charles X. McCalla, Paoli	Phillip T. Hodgin, Orleans
Owen-Monroe	Brad Bomba, Bloomington	Philip R. Karsell, 3901 E. 3rd St., Bloomington
Parke-Vermillion	John Somerville, Clinton	Milton Herzberg, Clinton
Perry	Robert Gilbert, Tell City	Gene E. Ress, 507 Main St., Tell City
Pike	M. H. Omstead, Petersburg	M. H. Omstead, Petersburg
Porter	John E. Read, Chesterton	Milton R. Carlson, 14000 Central, Portage
Posey	Paul Boren, Poseyville	Herman Hirsch, 130 W. 5th St., Mt. Vernon
Pulaski	Henry R. Eshelman, Monterey	E. L. Hollenberg, 613 Tippecanoe Dr., Winamac
Putnam	James B. Johnson, Greencastle	Anne S. Nichols, 707 E. Seminary, Greencastle
Randolph	Howard W. Koch, Winchester	Paul W. Sparks, 214 S. Main St., Winchester
Ripley	Bill E. Freeland, Batesville	William J. Warn, Milan
Rush	Donald I. Dean, Rushville	Charles E. Sheets, Manilla
St. Joseph	Jacob Rosenwasser, Mishawaka	L. F. Sandock, 503 Sherland Bldg., South Bend
		Mr. Harry Davis, Exec. Secy., 106 W. Monroe, South Bend
Scott	Ignacio B. Castro, Shelbyville	Jesus C. Bacala, 69 Wardell St., Scottsburg
Shelby	P. M. Inlow, Shelbyville	R. P. Inlow, 103 W. Washington St., Shelbyville
Spencer	John C. Glackman, Jr., Rockport	Michael O. Monar, Rockport
Starke	Earl Leinbach, Hamlet	W. Allen Palmer, Knox
Steuben	Mary H. Cameron, Angola	Richard W. Artz, 416 E. Maumee St., Angola
Sullivan	Glen McClure, Sullivan	J. S. Brown, Carlisle
Tippecanoe	L. H. Wagner, Lafayette	Chester L. Waits, 49 N. 26th St., Lafayette
Tipton	Robert L. Haller, Kempton	Albert E. Stouder, Kempton
Vanderburgh	Ralph Carlson, Evansville	Mr. Arthur P. Tiernan, Exec. Secy., 109½ S. E. 3rd., Evansville
Vigo	John Freed, Terre Haute	Robert L. Meissel, 920 N. 19th St., Terre Haute
Wabash	Fred C. Poehler, LaFontaine	Frank Smyrniotis, 645 Spring St., Wabash
Warrick	Peter B. Hoover, Boonville	Robert C. Colvin, Newburgh
Washington	Eddie R. Apple, Salem	Truman L. Chastain, 906 W. Mulberry, Salem
Wayne-Union	John Stepleton, Richmond	John Dehner, Reid Memorial Hospital, Richmond
Wells	Charles Caylor, Bluffton	R. D. Willard, R. R. 4, Bluffton
White	W. M. Dickerson, Monticello	M. Ali Jehanyar, 116 N. Illinois, Monticello
Whitley	Verlin P. Huffman, S. Whitley	Thomas Hamilton, 115 S. Main St., Columbia City



Is it depression?

He says "It's my stomach..."

...but his other symptoms:

functional somatic complaints, anxiety, insomnia, anorexia, feelings of guilt strongly suggest an underlying depression.

when the diagnosis is depression

ELAVIL® HCl (AMITRIPTYLINE HCl | MSD)

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.

MSD **MERCK SHARP & DOHME** Division of Merck & Co. Inc. West Point Pa 19486

WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

ISMA Committees and Commissions for 1967–1968

COMMITTEES

Executive
Ralph V. Everly, Indianapolis, chairman; Burton E. Kintner, Elkhart; G. O. Larson, LaPorte, President; Patrick J. V. Corcoran, Evansville, President-Elect; Lowell H. Steen, Whiting, Chairman of the Council; Lester H. Hoyt, Indianapolis, Treasurer; Malcolm O. Scamahorn, Pittsboro, Assistant Treasurer.

Grievance
Philip B. Reed, Indianapolis, chairman; Eugene S. Rifner, Van Buren, vice-chairman; Robert G. Young, Marion, secretary; Kenneth L. Olson, South Bend, Earl W. Mericle, Indianapolis; Richard Bloomer, Rockville; John M. Paris, New Albany; Wilson L. Dalton, Shelbyville; William R. Noe, Bedford.

Student Loan
G. O. Larson, LaPorte; Lester H. Hoyt, Indianapolis; Glenn W. Irwin, Indianapolis; Donald R. Taylor, Muncie; James O. Ritchey, Indianapolis; Lester D. Bibler, Indianapolis; Mr. Robert Robinson, Indianapolis.

Medical-Legal Review
Lall G. Montgomery, Muncie; Truman E. Caylor, Bluffton; E. Rogers Smith, Indianapolis

COMMISSIONS

Aging
George M. Young, Gary, Chairman; A. W. Cavins, Terre Haute, Vice-Chairman; Raymond Duncan, Bedford, Secretary; Bernard B. Rosenblatt, Evansville; R. E. Buckingham, Bloomington; Walter S. Fisher, Columbus; Glen A. Ramsdell, Richmond; John O. Butler, Indianapolis; John Cullison, Muncie; Wallace R. Van Den Bosch, Lafayette; George W. Wagoner, Delphi; Nathan Salon, Fort Wayne; Donald T. Olson, South Bend; Andrew C. Offutt, Indianapolis; Wendell C. Anderson, Indianapolis.

Constitution and Bylaws
Gordon S. Fessler, Rising Sun, Chairman; William M. Sholty, Lafayette, Vice-Chairman; James F. Lewis, Liberty, Secretary; George W. Willison, Evansville; Thomas H. Gootee, Jasper; M. C. Topping, Terre Haute; Joseph F. Ferrara, Franklin; B. D. Wagoner, Union City; Chester L. Waits, Lafayette; O. L. Marks, East Chicago; Richard L. Glendening, Logansport; John S. Farquhar, Fort Wayne; Edwin C. Mueller, La Porte; Burton Kintner, Elkhart.

Convention Arrangements
Charles H. Aust, Fort Wayne, Chairman; Durward W. Paris, Kokomo, Vice-Chairman; William M. Kendrick, Mooresville, Secretary; Richard B. Hovda, Evansville; William F. Howard, Bloomington; Irvin Sonne, New Albany; Merritt O. Alcorn, Madison; John E. Freed, Jr., Terre Haute; John Mader, Richmond; Francis E. Stout, Muncie; Boyd A. Burkhardt, Tipton; John L. Ferry, Whiting; James D. Finfrock, Elkhart; Kenneth Kohlstaedt, Indianapolis; Charles Fisch, Indianapolis.

Governmental Medical Services
Charles Hendrix, Vincennes; Guy H. Waldo, Bedford; Herman Echsner, Columbus; Dick J. Steele, Greencastle; Tom S. Shields, Richmond; Robert P. Scott, Indianapolis; J. F. Hinchman, Parker; Ramon B. Dubois, Lafayette; Edward J. Dierolf, Gary; George D. Buckner, Fort Wayne; D. D. Swihart, Elkhart; Jerome E. Holman, Jr., Indianapolis; Glen V. Ryan, Indianapolis.

Inter-Professional Relations
Fred Flora, Frankfort, Chairman; Virgil E. Angel, Highland, Vice-Chairman; William S. Robertson, Spiceland, Secretary; A. Wayne Ratcliffe, Evansville; Philip R. Karsell, Bloomington; Charles X. McCalla, Paoli; John W. Ripley, Seymour; Richard L. Veach, Bainbridge; Willis W. Stogsdill, Indianapolis; Wendell Covalt, Muncie; H. H. Dunham, Wabash; Pierre C. Talbert, Bluffton; A. Alan Fischer, Indianapolis; Robert G. Husted, Munster.

Legislation
Dwight W. Schuster, Indianapolis, Chairman; Don E. Wood, Indianapolis, Vice-Chairman; Jack W. Hickman, Indianapolis, Secretary; Daniel M. Hare, Evansville; Harold Manifold, Bloomington; Elmer L. Wallace, New Albany; Leslie M. Baker, Aurora; Fred W. Dierdorf, Terre Haute; John Davis, Flat Rock; Guy A. Owsley, Hartford City; Max N. Hoffman, Covington; Daniel Ramker, Hammond; Lester Renbarger, Marion; Eugene F. Senseny, Fort Wayne, Otis R. Bowen, Bremen.

Medical Economics and Insurance
Thomas G. Hamilton, Columbia City, Chairman; Thomas J. Conway, Terre Haute, Vice-Chairman; Chester A. Stayton, Jr., Indianapolis, Secretary; Charles M. Sinn, Evansville; Paul W. Holtzman, Bloomington; Edward J. Ploetner, Jasper; William A. Johnson, North Vernon; David R. Cain, New Castle; James M. Leffel, Indianapolis; Charles E. Geckler, Muncie; Kenneth O. Neumann, Lafayette; A. S. Kobak, Valparaiso; Richard Wagner, Huntington; Jack W. Hannah, Elkhart; William J. Miller, Lafayette.

Medical Education and Licensure
James B. Johnson, Greencastle, Chairman; John L. Cullison, Muncie, Vice-Chairman; Forrest LaFollette, Hammond, Secretary, John Sterne, Evansville; Betty Dukes, Dugger; John M. Paris, New Albany; Richard A. Snapp, Columbus; Frank Coble, Richmond; George T. Lukemeyer, Indianapolis; William Ringer, Williamsport; Leo Radigan, Gary; Lowell J. Hillis, Logansport; Joel Salon, Fort Wayne; Jene R. Bennett, South Bend; Merritt O. Alcorn, Madison; Peter J. Pilecki, Michigan City; Glenn W. Irwin, Jr., Indianapolis.

Public Health
T. O. Middleton, Bloomington, Chairman; Henry G. Nester, Indianapolis, Secretary; Daniel Hare, Evansville; Roy L. Fultz, Salem; R. M. Seibel, Nashville; Cleon M. Schauwecker, Greencastle; Wilson L. Dalton, Shelbyville; Stanley W. Burwell, Muncie; Theodore C. Person, Veedersburg; Gilbert Z. Given, East Chicago; Paul Sparks, Winchester; Theodore J. Smith, Whiting; Bertram Roth, Indianapolis; Charles H. Rushmore, Indianapolis, consultant.

Public Information
Frederic L. Schoen, Fort Wayne, Chairman; William B. Challman, Evansville, Vice-Chairman; William G. Moore, La Porte, Secretary; Louis Blessinger, Corydon; Herman J. Echsner, Columbus; William G. Bannon, Terre Haute; Robert D. Spindler, Shelbyville; Robert W. Harger, Indianapolis; Don W. Boyer, Lebanon; Thomas C. Chael, Munster; Fred C. Poehler, La Fontaine; Louis F. Sandock, South Bend; Loren H. Martin, Indianapolis.

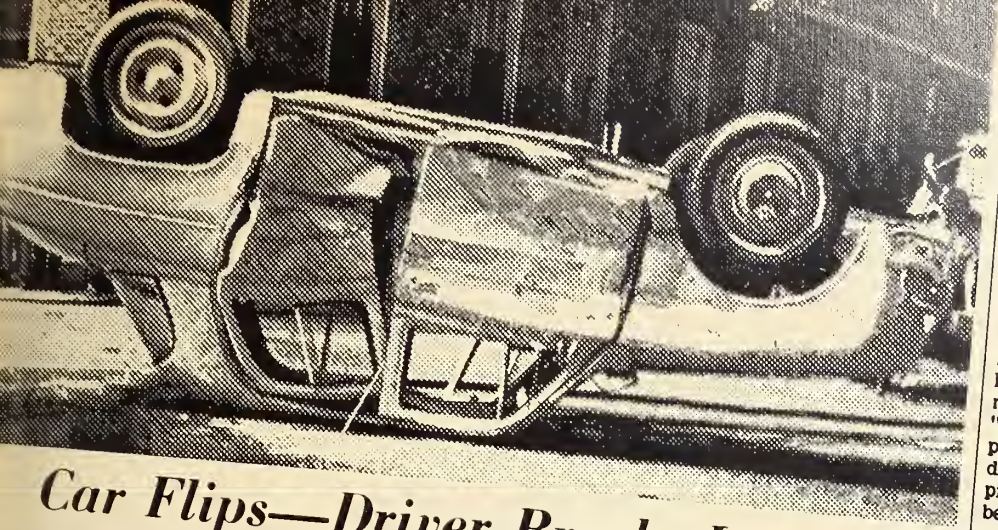
Special Activities
Marvin E. Priddy, Fort Wayne, Chairman; Robert M. Brown, Marion, Vice-Chairman; Norbert M. Welch, Vincennes; Robert O. Zink, Madison; John E. Freed, Jr., Terre Haute; Harold C. Ochsner, Indianapolis; Henry Bibler, Muncie; Clarence G. Kern, Lebanon; Adolph Walker, East Chicago; K. G. Hill, New Castle.

Voluntary Health Agencies
Norman R. Booher, Indianapolis, Chairman; James H. Gosman, Indianapolis, Vice-Chairman; M. O. Scamahorn, Pittsboro, Secretary; Albert Ritz, Evansville; Ed R. Cantwell, Vincennes; T. A. Neathamer, Scottsburg; Harry R. Baxter, Seymour; William G. Bannon, Terre Haute; Wayne Endicott, Greenfield; William A. Karsell, Indianapolis; James S. Fitzpatrick, Portland; Albert E. Applegate, Frankfort; John G. Kolettis, Gary; Lloyd L. Hill, Peru; Richard Willard, Bluffton; Frank McGue, Michigan City.

Future Planning Committee
Earl W. Mericle, Indianapolis, chairman; Maurice E. Glock Fort Wayne; James S. Fitzpatrick, Portland; A. Wayne Ratcliffe, Evansville; Fred S. Carter, LaPorte; William B. Challman, Mount Vernon; James E. Wenger, Nappanee; Charles F. Gillespie, Indianapolis; Leslie M. Baker, Aurora, (Ex-Officio Members)—Patrick J. V. Corcoran, Evansville; G. O. Larson, La Porte; Lowell H. Steen, Whiting; Ralph V. Everly, Indianapolis; Frank B. Ramsey, Indianapolis.

1967-68 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	R. E. Weitzel, Princeton	Fred Smith, Tell City	
2.	Brad Bomba, Bloomington	J. S. Brown, Carlisle	
3.	Daniel H. Cannon, New Albany	Elmer L. Wallace, New Albany	April 2, 1969, New Albany
4.	Bill E. Freeland, Batesville	William J. Warn, Milan	
5.	Jack Somerville, Clinton	Milton Herzberg, Clinton	
6.	Stephen Smith, Knightstown	David Wynegar, Richmond	
7.	John O. Butler, Indianapolis	Donald E. Stephens, Indianapolis	
8.	F. E. Stout, Muncie	Richard N. Philbert, Muncie	June 4, 1969, Muncie
9.	Martin Dickerson, Monticello	M. Ali Jehanyar, Monticello	May 22, 1969, Lafayette
10.	John J. Reed, Hobart	Raymond Doherty, Crown Point	
11.	Charles Wise, Camden	Fred Poehler, La Fontaine	
12.	Kenneth F. Isenogle, Fort Wayne	John J. Hartman, Angola	May 21, 1969, Fort Wayne
13.	E. C. Mueller, LaPorte	John Hildebrand, South Bend	



STAFF PHOTO

Car Flips—Driver Breaks Leg

...us, Sept. 7. John P. Jones of ... incurred a broken leg today ... driving ... Patrolman B. R. Brown, the car hit a fire hydrant and flipped over on its ... Hasn't he ... itar

issue, a... tember ti... fications' ... ton dicta... Althou... made Mo... down by a ... ter shar... flat obje... was pass... Board ... McCredi... tion" s... elimir... the st... The c... ment ca... limit ra... mile li... "cut-of... public ... dren ... priv... be b... or th... schoo... The ... so so... rather ... hurs...

He's had enough excitement for one day.

For the patient who has been through an accident, the worry and anxiety following the experience may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—*to take the nervous "edge" off,* so the rest of the formula can control the pain more effectively.

Phenaphen® with Codeine

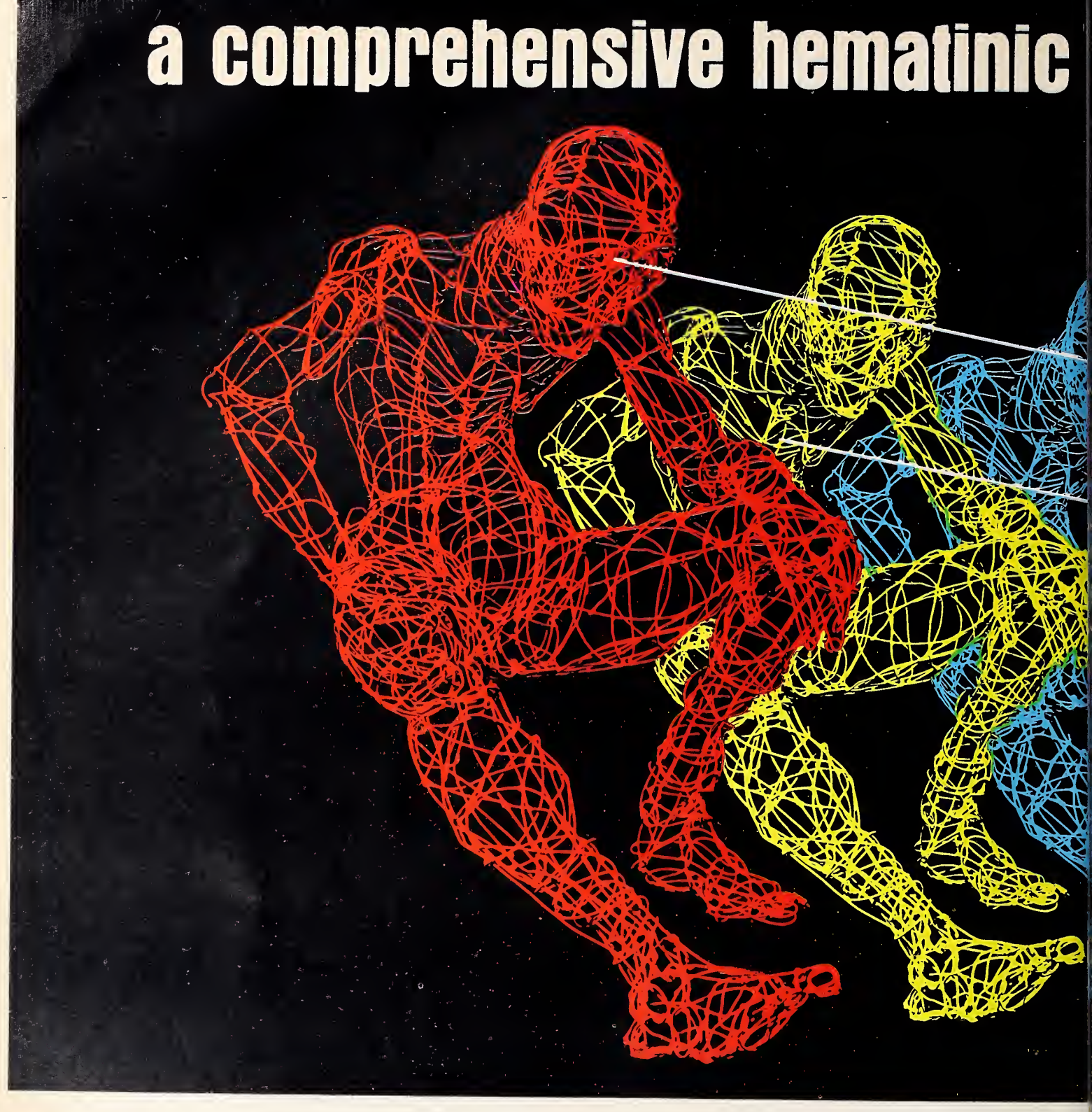
Phenaphen® with Codeine No. 2, No. 3, or No. 4 contains: *Phenobarbital* (¼ gr.), 16.2 mg. (Warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4). (Warning: may be habit forming).

THE COMPOUND ANALGESIC THAT CALMS INSTEAD OF CAFFEINATES

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** 1 or 2 capsules at 2 to 4 hour intervals, or as directed by physician. For further details see product literature.

A. H. ROBINS COMPANY
RICHMOND, VA. 23220 A·H·ROBINS

a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150 mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5 mcg.
Iron, Elemental (as Ferrous Fumarate)	110 mg.
Ascorbic Acid (Vitamin C)	75 mg.
Folic Acid	1 mg.

Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequate vitamin B_{12} therapy may result in hematologic remission but neurological progression. Adequate doses of vitamin B_{12} (parenteral or oral with potent intrinsic factor as in Trinsicon® [hematinic concentrate with intrinsic factor, Lilly]) usually prevent, halt, or improve the neurological changes.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potentiation of absorption of physiological doses of vitamin B_{12}. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B_{12}, may be necessary. No single regimen fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Periodic

You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500. [032568]

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206.

801668

Lilly

In peptic ulcer: the antacid puzzle

solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

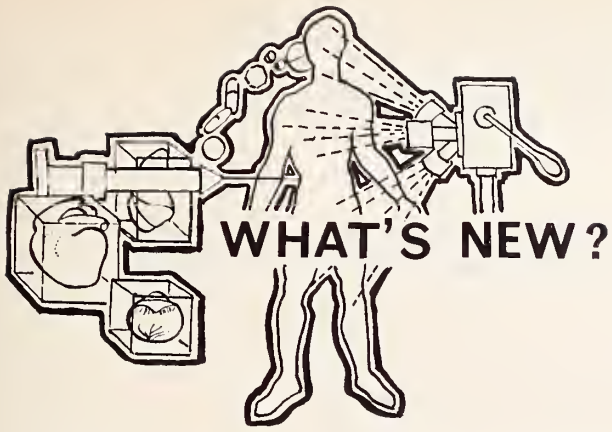
Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O. K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.. Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.



WHAT'S NEW?

Travenol Laboratories announce an improvement for their Cystoflo™ Urinary Drainage Bag by the addition of a bottom drain and a portable metal hanger. The "trapdoor" tube allows the bag to be drained by gravity. The new hanger is suitable for suspending the bag from the patient's bathrobe belt, or from a chair seat, or may be used to hand carry it.

* * *

Attractive recipes for allergy diets is the specialty of a booklet by *Good Housekeeping*. A 44-page booklet containing 125 recipes provides helpful hints for the cook who is preparing food for those who are allergic to milk, eggs, wheat or gluten. Included are recipes for cakes, cookies and bread as well as those for other desserts, soups, main courses, vegetables and salad dressings. The cost is 50 cents. Write Good Housekeeping Bulletin Service, 959 Eighth Ave., New York City 10019.

* * *

A new Pfizer diagnostic test provides for rapid measurement of serum cholinesterase. The product is trademarked ChE-tel and is the first Pfizer entry in clinical enzymology. It will be especially useful in helping to determine liver function and in measuring the fall in the enzyme in pesticide poisoning. One test set will run 50 determinations and if stored between 2° and 8°C. will be stable for one year.

* * *

Upjohn has reduced the price of Panalba® Capsules and Panalba Half-Strength Capsules by 20%. This is the third time this family of products has been reduced. Panalba KM® Granules (including the recently released new large sizes— 80 cc. and 150 cc.) have been reduced 10%.

* * *

Parke-Davis has announced a new single-unit size of the injectable vitamin B_{12} product Sytobex. The new disposable unit-dose dispensing package will be called "Sytobex Steri-Dose Syringe No. 10." It will contain 1,000 mcg. of crystalline vitamin B_{12} per cc.

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments, and surgical appliances and book publishers. Each item is published as news and does not necessarily constitute an indorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

THE BETTMANN ARCHIVE

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Finally...a salicylate superior to aspirin?

Not at all, Doctor...but

magan®

(magnesium salicylate, W-T)

should be considered for your arthritic and rheumatic patients who cannot tolerate aspirin.

Surveys * made in 1966 and 1967 among private practice physicians showed an incidence of intolerance to aspirin ranging from 3-85%. The majority of physicians surveyed reported an intolerance in 10-30% of their patients.

How does this compare with your experience?

*by two independent national research organizations

WARREN-TEED PHARMACEUTICALS INCORPORATED
COLUMBUS, OHIO 43215
SUBSIDIARY OF **ROHM AND HAAS COMPANY**

10-30

Don't use Magan on all your patients–

consider Magan for those patients who cannot take aspirin because of gastric discomfort

Private Practice Physicians tried Magan on almost 700 patients whom they judged intolerant to aspirin and other salicylates.

The majority of these patients could take Magan and obtain the benefit of salicylate therapy.

magan® **an alternate salicylate**

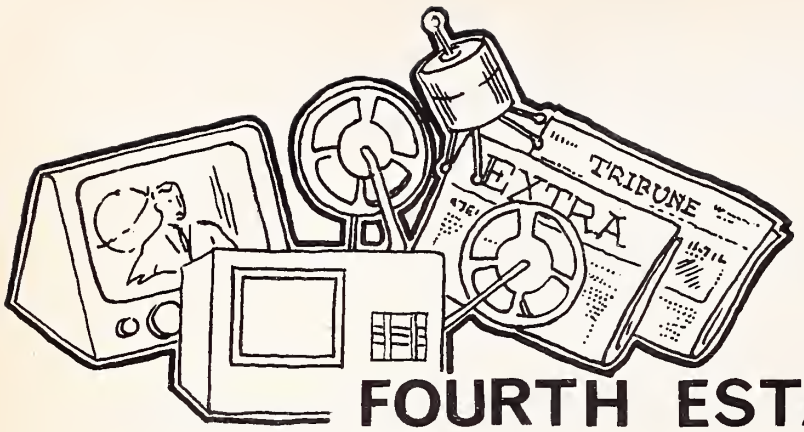
(magnesium salicylate, W-T)

May be tolerated by some persons intolerant to aspirin by reason of gastrointestinal irritation.

Magan is a new salicylate product from Warren-Teed.

A single chemical entity . . . no coating, no buffering, sodium free and non-acetylated.

Composition: Each orange colored tablet contains 5 grains (approx. 325 mg) of magnesium salicylate.
Dosage: 1 or 2 tablets every 4 hours with a full glass of water.



FOURTH ESTATE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Editorial in Medical Journal

Editor, The Times-Union:

Did you know that your very nice editorial about my late husband, Dr. Dan Urschel, was in the May issue of the *Journal of the Indiana State Medical Association?*

I appreciated it when you wrote it, and today I appreciate it all over again. Thank you.

Yours sincerely,
RUTH URSCHEL
Mentone, Ind.—*Warsaw Times-Union*, May 29, 1968.

James W. Carr

If it were written in the record book only that James W. Carr helped one crippled child to walk, that would be enough to bring peace to Jim's soul.

The fact is that most of a long and richly productive lifetime was poured unstintingly into work which has helped make it possible for thousands of crippled children to receive care and treatment which added movement and comfort and happiness to their lives.

The opportunity and ability to do this brought great happiness to Jim. It also brought him a driving, insatiable compulsion to do more. He knew the children who came and went at James Whitcomb Riley Hospital. He saw them, talked with them, agonized with them, and translated his compassion for them into doing what there was for him to do to make Riley the best it could be.

From the time in 1922 he was taken on by the then infant Riley Memorial Association to help raise funds to build it, that hospital and the needs of crippled children became Jim's reason for being. With his quiet, persuasive competence he contributed immeasurably to the successful development of the hospital, its staff, and the association.

We don't know what's written in the books. But written in his heart was the serenity of a life well spent. —*Indianapolis Star,* May 29, 1968.

Reversing the Drain

Every so often we hear about a so-called "brain drain" in the Midwest in general and in Indiana in particular. The "drain" consists of graduates from the state's public universities taking their tax-subsidized skills to other parts of the country, usually the West.

At least in one area, this trend has been reversed. According to the dean of the Indiana University School of Medicine, there are 18% more medical school graduates interning in Indiana this year than in 1967. Dr. Glenn W. Irwin Jr. calls the trend "a heartening development for Indiana" because doctors tend to establish their practices in the states where they intern.

It also is heartening that I.U. Medical School graduates are interning in more Hoosier cities than last year. In the past doctors have tended to concentrate in the biggest cities, interning where they hoped to practice. This meant fewer doctors for the smaller towns.

The influx of doctors is important to Indiana not only because it means better health care for Hoosiers but also because it can influence professional and skilled people to immigrate to Indiana. A good physician-patient ratio is one factor business considers when it is looking at industrial sites for company expansion.

In various ways, then, the reversing of the brain drain is important to Indiana. It suggests that the loss of skilled college-trained people from the state is not a permanent affliction but a problem which will yield to purposeful effort.—*Indianapolis News*, June 18, 1968.

Best Approach to Medical Issue

The 1969 Indiana General Assembly, likes its predecessor in 1967, will have to come to grips with the need to expand medical education in the state.

The next Assembly can avoid much time-consuming frustration if it studies the lesson of the 1967 legislature and re-enacts the law which ran afoul of Gov. Roger Branigin's veto —— minus the preliminary skirmishing and maneuvering.

And both state parties. Demo-

cratic and Republican, can make a useful contribution to the orderliness of the 1969 Assembly by inserting that advice in their respective party platforms at the party conventions in Indianapolis next week.

The bill which ended up with almost everybody's support but the governor's in 1967 would have created a Medical Education Authority charged with determining "what program will best . . . expand the medical training resources" of Indiana.

The proposed "blue ribbon commission" would have decided whether to stretch the Indiana University Medical Center of Indianapolis or to establish one or more new medical education facilities in the state. And it would have had the authority to decide where the latter ought to be located.

The act was a compromise hammered out with bipartisan support in both houses of the Assembly after representatives of competing regional sites battled one another to a draw. The governor then upset everything by vetoing the act.

Rather than going back into a bare-knuckled site-battle in 1969, the new Assembly would be wise to re-enact the 1967 proposal, creating a commission of specialists to determine how and where to meet the state's undeniable medical education needs.

The South Bend area, one of the major site contenders, would be satisfied to see its case presented to a blue-ribbon commission, because we are confident that our site credentials are impressive.

The party platforms, either as drawn up for presentation to the conventions or as amended from the convention floor, could do a great service in removing the medical education issue from partisanship.

Both parties' platforms ought to endorse the 1967 blue-ribbon medical act, boldly and unmistakably. It is the only reasonable way to approach the medical education issue. —*South Bend Tribune*, June 11, 1968.

Pushing Medical Education

Three separate developments over the past weekend concentrated new attention on a national problem which is of peculiar concern to Northwest Indiana—medical education.

One was the proposal by Rep. F. Edward Hebert, D-La., of the House Armed Services Committee that the Armed Services set up a "West Point for Doctors" in which medical education would be provided to those young students willing to serve their first few years with one of the military branches.

Another was a statement by Secretary of Health, Education and Welfare Wilbur J. Cohen. In outlining a restructuring of the federal health services, he asserted that health efforts generally are "weakened by a shortage of trained physicians and allied health workers."

The third was a gift by a Chicago legal and business family of $12,000,000 to the University of Chicago to upgrade that institution's already highly respected school of medicine.

What all that underlines is the fact that the shortage of doctors and of medical technicians is not just an Indiana problem, but a generally recognized national problem as well.

All the more reason why the next Indiana Legislature should push ahead with the final authorization of that new medical school which everyone is convinced is needed. All the more reason, too, why Lake County and other parts of Northwest Indiana should put back into high gear the campaign for location of such a facility here where it is most needed, and where the potential, including the new stepped-up Gary hospital construction, is best fitted.

In part it's a civic job, and the overwhelming success of the Greater Gary Joint Hospital fund drive indicates the concern at that level. The very high rate of contribution by physicians and those in related professions shows their concern, too. But it's also a political problem, and some progress in the general direction might well be made by Northwest Indiana delegations involved in this week's state nominating convention and subsequent strategy sessions.—*Gary Post-Tribune*, June 21, 1968.

Training More Doctors

The plan of Ball State University to establish a two-year medical education program appears to be a practical approach to a serious problem.

The problem is a critical shortage of doctors. It is one that grows more urgent as Indiana's population increases while its medical education facilities remain comparatively static.

Dr. John R. Emens, Ball State president, said the program would call for the admission of 32 first-year medical students by September, 1970. It would be operated in conjunction with the Indiana University Medical School, and after the students had completed their first two years, they would be encouraged to transfer to the I.U. Medical School to complete their work.

One of the advantages of such a program is that existing facilities at Ball State could be used for this purpose. Ball State ranks high academically and the faculty members there could be relied upon for a top-quality educational program. Eventually, the program could be expanded to a full four-year course, eliminating the need for transfers.

Such a program should have a far-reaching effect in encouraging prospective doctors to obtain their medical education within the state. This in turn would increase the number of doctors, since medical school graduates have a tendency to practice in the area where they receive

their education and internships.

The plan would require $375,000 for operation in the first two years of its existence. Consequently, it will be submitted to Gov. Roger D. Branigin, the state budget agency, the state budget committee and the state policy commission on post-high school education.

There is no apparent reason why these agencies should not give it favorable consideration. It is a workable plan to increase medical education without excessive expenditures. —*Indianapolis News*, July 1, 1968.

Costly "Hot Pursuit"

Each year 500 or more Americans are killed in "hot pursuit" of errant motorists by police. Twice as many sustain major injuries. The pity is that most of the lawbreakers involved are guilty only of minor traffic offenses.

In the first report known to have been made of the toll of life and injury in hot pursuits, an organization known as Physicians for Automotive Safety reported on a survey made between April and June last year. In 512 hot pursuit cases, 119 persons lost their lives and 272 sustained serious injuries. Of the deaths, 52 were drivers of pursued cars, 33 were passengers in cars being pursued, 23 were passengers in other vehicles, five were pedestrians and five policemen.

Since seven out of ten pursuits end in accidents with death and injury for those involved and innocent bystanders, it is obvious that this is a pretty sad way to enforce traffic laws. Especially when in only one percent of the cases was someone in the car wanted for a violent crime, although 20% of the pursued cars had been stolen.

The physicians urge that hot pursuit be limited to cars in which violent crimes have been committed, and then not in residential and densely populated areas. There must be better ways to recover stolen cars. —*Logansport Pharos-Tribune & Press*, July 2, 1968.

I.U. Medical Center

Why is there such a shortage of doctors?

The obvious answer is that enough doctors to meet the present needs are not being graduated from our Indiana University Medical Center.

There may be another answer, as an inadequate attraction for interns to finish their training in Indiana hospitals.

It appears obvious that if the state graduated more doctors and gave experience to the interns, communities throughout Indiana should have in a few years a more ample supply of physicians.

To meet this need, the program of having another medical school, as at Ball State, has been and is being pushed.

A compelling argument against this plan has come to this newspaper's attention.

What is needed now, more than anything, to make more doctors, is to enlarge and strengthen the Medical Center. For years that institution has been neglected, due to lack of state financial support. The budget has been far too low. To refer to the Medical Center as a state-supported school is to distort the facts.

Last year the state paid but 44.6% of the medical school budget. The major portion of the budget came from federal grants and from foundations and individuals.

The Medical Center needs strengthening by larger appropriations from the state for equipment and professors so that more and more medical students may be trained.

We have been told that the idea that is widely held that the medical profession tries to hold down the number of graduates is absolutely not true. We all know that many well qualified young people would like to be doctors.

Therefore, we return to our original statement that the obvious answer to a scarcity of doctors is to strengthen the medical school with more room, more and better equipment and more instructors.

This would be a good way to invest more of our tax money, as it would benefit the entire population, including many doctors who have more work than they can do.

Another sound idea, we believe, to achieve this needed improvement in medical and health care, would be to encourage health clinics in every appropriate district, where a suitable number of doctors could work in cooperation in the use of facilities that would be uneconomical for the use of one or two physicians. In that way, too, emergency care or treatment would be more readily available around the clock.

Overhead could be reduced, thus reducing costs.

This newspaper's source of information on this subject has suggested that citizens who are interested could well take the time to visit the Medical Center to observe and study the conditions there.

It has also been suggested that members of the Indiana General Assembly should give closer attention to the Medical Center and see that needed funds are allocated to it.—*Martinsville Reporter*, July 3, 1968.◀

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® tablets in two different formulations.

And let you control the dosage.

Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.
Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

With Novahistine LP tablets and Novahistine Singlet™ tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

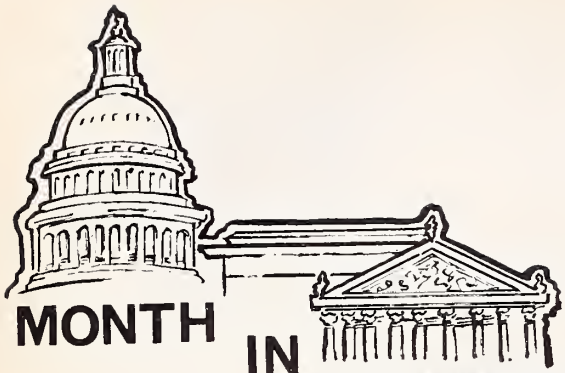
Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever. Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

DOW PITMAN-MOORE DIVISION OF THE DOW CHEMICAL COMPANY, INDIANAPOLIS

"Nothing else I've tried seems to work, so I decided to give you a crack at it."



MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

WASHINGTON, D.C.—"Improving the quality of life in this country requires that far greater national effort be devoted to reducing the incidence of preventable diseases, accidents and premature death."

THIS WAS the theme of a proposal to President Johnson to establish a Commission on Disease Prevention and Health Protection, appointed by the President, to make recommendations within a year.

THE PRESIDENT was told that "to continue the present national emphasis upon treatment and after-the-fact remedies, as opposed to prevention, must be regarded as a failure of the health professions to adequately protect the public."

SAID THE PLAN'S sponsors, headed by Sen. Warren Magnuson (D., Wash.), Chairman of the Senate Commerce Committee:

"MANY of the diseases currently prevalent can be prevented entirely. Others can be detected and cured in the early stages. In some cases, it is simply a question of instilling awareness, recognizing symptoms or the importance of diet, and exercise. Technical personnel and automated laboratory and computerized recording procedures can utilize known techniques to operate comprehensive screening programs. These prevention and early detection programs can save money and conserve scarce physician time. People can be educated to expect health rather than to tolerate illness, to demand prevention rather than to admire belated treatment."

THE STATEMENT continued:

"BENEFITS can be derived through legislation. Others will accrue through public and professional education. Still further benefits would come from financial support for special professional and non-professional training in the practice of preventive medicine. The following are just a few examples of things that can be done now. For example, we now have the authority to clean the polluted air over most of the major urban areas of this country.

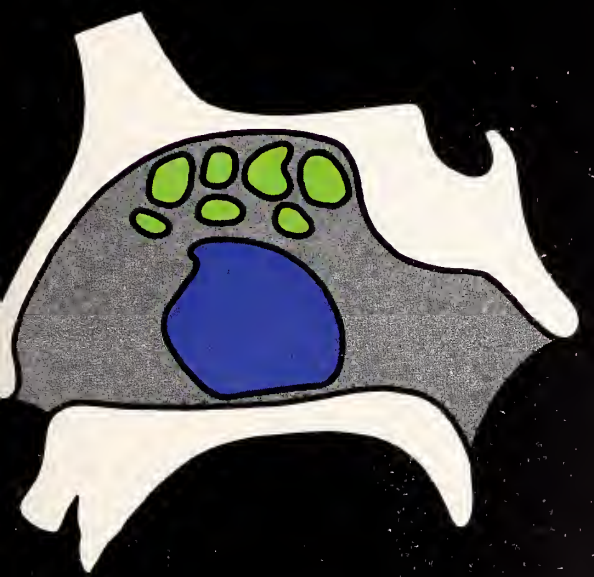
"OTHER APPROACHES include new methods of paying for and organizing health services. We, at present, invest huge sums in medical care, through public and private support. The same means of coverage, however, such as Title XVIII, do not provide for 'health protection': there is no payment for periodic health appraisal on an out-of-hospital basis, with provision for follow-up care. This should include individual and group

Continued on page 1207.

Sources of sinus headache

REGION OF SENSATION

FRONTAL SINUS—headache localized over the frontal region, commonly beginning in the morning. Eyes painful to touch, may be slight swelling over eyes, puffy eyelids.
SPHENOID SINUS—most difficult to diagnose. Headache or sense of pressure over vertex. May be pain in ear or mastoid region.



MAXILLARY SINUS—headache and tenderness under eyes at top of cheekbones, usually starting in early afternoon. Possible swelling of cheek. Pain in jaw and back teeth.
ETHMOID SINUS—headache, tightness in upper part of bridge of nose and well down its sides. Pain, deep-seated behind the eyes and in inner corners of the eyes.

TURBINATES—pain along medial and lateral walls of the inside of the nose. Headache in frontal region, along supraorbital ridge, a feeling of fullness in the head.

during times of manpower and fiscal shortages on which future (medical research) success is dependent."

IN APPOINTING Dr. Marston, President Johnson said the new NIH director faces a "staggering job" because not only the United States, but the entire world needs "rescue from death and disability that medical research promises."

PRESIDENT JOHNSON expressed the hope that Dr. Marston's leadership in research would play an important role in an effort to reduce the death rate from serious diseases by 10% by 1976.

NEW CENTER ESTABLISHED, NAMED FOR LATE CONGRESSMAN

THE JOHN E. FOGARTY International Center for Advanced Study in the Health Sciences has been established in memory of the late Rhode Island congressman who was a leader in health legislation for many years. Congress provided an initial appropriation of $500,000 for the new center to start operation in the National Institutes of Health until its own building is completed. The center's first director is Dr. Milo D. Leavitt, Jr., who had been director of the NIH Office of Program Planning.

ATTORNEY GENERAL APPEALS FOR SUPPORT OF DRUG LAWS

U.S. ATTORNEY GENERAL Ramsey Clark appealed for broad support and cooperation of the public in enforcement of the laws against marijuana and LSD. Otherwise, he said, the law cannot be enforced effectively. Enforcement must be accompanied by research and education, he said and added: "The youth of today are extremely sophisticated about drugs, and they are also highly selective of the wave lengths they tune in on—the channels of information they select."

PRESIDENT NAMES NEW BIRTH CONTROL STUDY COMMITTEE

PRESIDENT JOHNSON named a special committee to develop a five-year program for providing more effective birth control. The study committee will be headed by HEW secretary Wilbur J. Cohen. Mrs. John D. Rockefeller, III, N.Y., will serve as his co-chairman. An official said one matter to be studied would be the fact that present methods of contraception are not adequate. He said the so-called "pill" is too expensive for widespread use in some areas and it was difficult to educate illiterate people in its use.

NIH ASKS FOR HALT IN BLOOD PLASMA SHIPMENTS

THE NATIONAL INSTITUTES of Health has asked processors of whole pooled human blood plasma to halt their interstate shipment because the substance has been causing hepatitis, an infection of the liver, in one out of 10 patients receiving transfusions. The move is expected to halt use of most such plasma, of which about

300,000 pints are given annually to about 100,000 patients in the United States. The agency acted on a report issued in April by the National Research Council saying use of whole pooled plasma should be discouraged and even discontinued because of the hepatitis danger.

TOO MUCH TALK, NOT ENOUGH ACTION ON ALCOHOLICS

THE SENATE HEALTH Subcommittee was told that the nation talks more and does less about its five million alcoholics than any of its other health problems. Michael Gorman, a spokesman for the National Council on Alcoholism, said that the losses from alcoholism are now running about $2 billion a year. Dr. Philip R. Lee, Health, Education and Welfare Assistant Secretary, supported Gorman. According to Dr. Lee, alcoholism is an "enormous economic liability to the nation" in terms of job absenteeism, lowered productivity and medical insurance expenses. ◄

Blessed event?

Not entirely, when nausea and vomiting occur in early pregnancy. Emetrol offers prompt and safe relief. Local rather than systemic action provides emesis control on contact with the hyperactive G.I. tract.* In a study of 123 pregnant women, the drug produced measurable improvement in 79% of patients in controlling vomiting.[1]

*As shown by *in vitro* studies.
1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.

Emetrol®
phosphorated carbohydrate solution
emesis control

ROER WILLIAM H. RORER, INC.
Fort Washington, Pa.

***"Now that your acne is clearing up nicely,
it might be a good idea if you started losing some weight."***

Get them while they're easily reversible.

Obesity doesn't happen suddenly. This insidious process has its beginning—and the chances of reversing it are better—during the *first 10 to 15 pounds of weight gain.* When a new dietary pattern must be established, consider the adjunctive use of BAMADEX SEQUELS. Combining the proven *anorexigenic* action of d-amphetamine with the *tranquilizing* effect of meprobamate, BAMADEX SEQUELS controls appetite throughout the day, usually with a single capsule daily.

Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.
Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Bamadex® Sequels®

Dextro-Amphetamine Sulfate (15 mg.) with Meprobamate (300 mg.) Sustained Release Capsules

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York

407-8

400,000 units of potassium penicillin V per teaspoonful

New...V-Cillin K®, Pediatric, 250 mg.

Potassium Phenoxymethyl Penicillin

Lilly

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

800192

The Journal of the INDIANA STATE MEDICAL ASSOCIATION
Supervised by THE COUNCIL
Volume 61 — September 1968 — Number 9

Clinical results from a group of eight patients with multiple sclerosis indicate improvement following intrathecal administration of methylprednisolone acetate.

The Treatment of Multiple Sclerosis with Intrathecally Administered Methylprednisolone Acetate

WILLIAM A. RINGER, M.D.
Williamsport

BECAUSE of the inexplicable remissions and the protean symptomatology of multiple sclerosis, any new treatment is always viewed with scepticism and intrathecally administered methylprednisolone acetate (Depo-Medrol*) is no exception. Even parenterally administered corticosteroids and ACTH have not been fully accepted, although they are widely used. Remissions attributed to these drugs are often transient and do not apparently differ from spontaneous remissions in comparable untreated patients. On the other hand, multiple sclerosis must be treated aggressively and a new therapy that has a reasonably sound rationale and that is not dangerous to the patient, deserves consideration.

I believe that intrathecally injected methylprednisolone is worthy of continued investigation. This opinion is based not only on my own experience but also on a growing body of literature that attests to its effectiveness and safety in the treatment of multiple sclerosis, sciatica and arachnoiditis.[1-6]

The rationale for the use of corticosteroids and ACTH is that multiple sclerosis is an autoimmune disorder in which an immunologic reaction initiates or participates in the myelin breakdown. Further, since this inflammatory component must be dealt with via the cerebrospinal fluid, it is logical that the drug should be delivered there. Corticosteroids and ACTH given parenterally do not easily cross the blood-brain barrier, and thus dosages large enough to provide therapeutic levels in the CSF may cause serious steroid side effects. While administering the corticosteroid intrathecally may not be particularly appealing to many physicians, it is in fact a fairly simple procedure and the lumbar punctures have not caused serious reactions.

Materials and Method

The essential information on the eight patients participating in this study is given in Table I. The neurologic classification of severity is: 1—mild; 2—mild to moderate; 3—moderate; 4—moderate to severe; 5—severe; 6—very severe. A mild case is one who has almost normal function; a very severe case is one who is bedridden. The dosage of methylprednisolone is similar to that recommended by Boines:[2]

First injection	1.0 cc.— 40 mg.
Two weeks after first injection	1.5 cc.— 60 mg.
Four weeks after second injection	2.0 cc.— 80 mg.
Six weeks after third injection	2.5 cc.—100 mg.
At eight week intervals or as required	2.5 cc.—100 mg.

The usual lumbar injection technic was followed. I use a 22 gauge Whitaker needle which has a very sharp point with the opening about 1 mm. behind the point. The dura is spread apart rather than pierced, as with a standard bevel-pointed needle, thus obviating to a great extent any trauma from the lumbar puncture, and any leakage of fluid from the subarachnoid space. A sample of cerebrospinal fluid is first removed

* The Upjohn Company, Kalamazoo, Mich.

PATIENT STUDY

Patient	Sex	Age	Duration of M.S. in Years	Months Treated	No. of Injections	Severity Before Therapy	Severity After Therapy
1	F	53	5½	16	10	4	3
2	F	72	24	13	8	6	4
3	F	47	7	13	12	4	2
4	M	37	7	9	7	5	6
5	M	49	5	13	10	5	4
6	F	27	3	22	11	6	2
7	F	30	3	7	5	3	1
8	F	44	7	14	11	6	4

TABLE I

for colloidal gold and total protein tests. Then the methylprednisolone is mixed with spinal fluid and slowly injected. After the injection, the patients are kept in a supine position for two hours.

In addition to methylprednisolone, I demand that each of the patients follow a regimen of physical exercise to improve strength and muscular coordination. A typewritten copy of exercises is given to each patient. Those exercises considered most beneficial for his state of disability are then checked and discussed carefully. The physiotherapy program is reviewed at each examination period.

Results and Side Effects

As shown in Table I, five patients showed marked improvement—their conditions improved by two points or more. Two patients showed moderate improvement indicating a one point change. One patient did not improve. This patient, a 37-year-old white male, had shown steady improvement after five injections over a period of three months when he was hospitalized with a respiratory infection, pleural effusion and pyelonephritis. His personal physician recommended that he receive no further spinal injections for eight weeks. After an uneventful recovery he was discharged from the hospital. Following this, the symptoms of multiple sclerosis began to reappear until the condition was about the same as when he was first examined. Thus while his response was initially good, he must be considered a failure. Therapy with methylprednisolone has been re-instituted with no positive response at this time after two injections.

The only important side effect was excessive weight gain in three patients—ranging from 21 to 32 pounds. Two other patients gained six and 10 pounds each. One patient had a mild spinal headache and another had duodenitis associated with methylprednisolone therapy. I am unable to account for this unusual weight gain; it could be attributed in part to improved health and subsequent better appetite. There were no side effects, other than the spinal headache, that could be attributed to the spinal injections.

The colloidal gold tests were either non-reactive or indicative of multiple sclerosis and the total protein tests ranged from 41 to 68 mg./ml.

Case Report

The following case report is representative of those patients who showed marked improvement:

Female, age 30. Occupation, registered nurse. Duration of multiple sclerosis, approximately three years. Symptoms began with backache, urinary urgency and frequency and partial numbness of the legs and waist. A neurosurgeon, after a complete neurologic examination including a myelogram, made a diagnosis of multiple sclerosis.

A few months later her symptoms became more severe. She was examined at the Mayo Clinic in June, 1965, and the diagnosis was confirmed. A laboratory analysis of her cerebrospinal fluid showed protein 37 mg. and gamma globulin 25%. A course of intrathecal methylprednisolone was considered at this time but ruled out because there was apparently no one qualified in her home town to give the follow-up injections.

She was started on paramethazone (Haldrone*) 4 mg. daily for an arthritic-like pain in her right knee. Although she developed Cushingoid symptoms, she was unable to discontinue the steroid because of recurrence of pain. Since June, 1965, the weakness and ataxia progressed until they severely limited her work as a nurse. She was unable to stand while assisting at sigmoidoscopies and had to stop working as an operating room supervisor.

At examination in February, 1966, she appeared well nourished and well developed with marked ataxia. She walked with a cane and had typical Cushingoid facies. The patient had fair muscle power in the lower extremities, although the right side was weaker than the left. The deep tendon reflexes were exaggerated in both the upper and lower extremities. There was no atrophy in the upper extremities and she showed good muscle power. The Romberg sign and the Babinski reflex were positive.

She was started on intrathecal methylprednisolone on February 7, 1966, and to date has received five injections. The paramethazone was immediately decreased to 2 mg. daily for two weeks and then discontinued with subsequent improvement in Cushingoid appearance. This patient has steadily improved from the beginning of therapy with methylprednisolone. She can now work in an emergency room for five hours without sitting down, and she has recently worked eight to 12 hours a day for 15 continuous days.

* Eli Lilly & Co., Indianapolis.

Discussion

While no positive conclusions can be drawn from this small series of patients, I believe that the study does add further confirmation to the studies of Boines.[1,2] In reviewing the literature and in discussions with other physicians, I feel that the objections raised against this technic are unfounded.

The argument that the patient would have had a remission without the intrathecal injections seems excessively conservative. This indeed may be true in some of my patients, but certainly the odds do not favor seven out of eight patients improving spontaneously.

While it is only presumptive evidence at this point, it would appear that there is an inflammatory factor in this disease, and corticosteroids are indicated. Further, the objection to giving a series of spinal injections because of possible side effects from the lumbar punctures is without sound basis. By using ordinary care and sterile technic, there is less danger to the patient than administering steroids parenterally, since there is less chance of systemic side effects.

I do attribute part of my success to the use of the Whitaker needle which causes less damage to the dura than the standard larger gauge bevel needle. Further, I believe that physiotherapy is important as an adjunct to methylprednisolone therapy—this must be insisted upon since the exercises force the patient to assume an active role in his battle with multiple sclerosis. While further investigation is required to confirm the usefulness of the intrathecal technic, I am satisfied that it will ultimately be accepted by many physicians.

REFERENCES

1. Boines, G. J.: Erratic Persistence of Intrathecally Injected Methylprednisolone Acetate, *Delaware State Med. J.* 36:210, (October), 1964.
2. Boines, G. J.: Predictable Remissions in Multiple Sclerosis, *Delaware State Med. J.* 35:200, (August), 1963.
3. Kulick, S. A.: The Clinical Use of Intrathecal Methylprednisolone Acetate Following Lumbar Puncture, *J. Mount Sinai Hosp. N. Y.* 32:75, (January-February), 1965.
4. Goldstein, N. P., McKenzie, B. F., McGuckin, W. F.: Changes in Cerebrospinal Fluid of Patients with Multiple Sclerosis After Treatment with Intrathecal Methylprednisolone Acetate: A Preliminary Report, *Proc. Mayo Clin.* 37:657, (December 5), 1962.
5. Sehgal, A. D., Gardner, W. J., Dohn, D. F.: Pantopaque "Arachnoiditis"—Treatment with Subarachnoid Injections of Corticosteroids, *Cleveland Clin. Quart.* 29:177, (October), 1962.
6. Sehgal, A. D., Gardner, W. J.: Corticosteroids Administered Intradurally for Relief of Sciatica, *Cleveland Clin. Quart.* 27:198, (October), 1960. ◄

About Our Cover

Score a bull's-eye for yourself and your patients—attend the 119th annual convention of the Indiana State Medical Association at Fort Wayne.

This issue of *The Journal* brings you the complete program and reports of officers. With it you can plan the programs you wish to attend and also get a preview of the scientific and technical exhibits.

Back this year will be the golf tournament and the Art and Hobby Show. Everything has been planned for your entertainment, relaxation and enlightenment.

In addition, you may plan to attend the general scientific and section meetings; elections of section officers; past president's luncheon; women physicians' dinner meeting; reception and luncheon for members of the 50-Year Club; the president's reception and dinner; fraternity luncheons; reference committee meetings and tour the scientific and technical exhibits.

The "movies" are not the only thing that are "better than ever"!—J.F.S.

Consecutive unselected psychiatric patients seen in a two-year period in a general psychiatric practice were found to have a high school dropout rate which varied from 33% to 100% in various categories. This is in contrast to a general dropout rate of 4.1% in the community. If this indicates that the dropping out of school was the first symptom manifesting a deep and serious psychological or psychiatric disability, would not a psychiatric approach to the dropout problem be superior to the customary environmental manipulation and/or occupational therapy approach?

An Evaluation of the Psychological Aspects of Dropouts

ROBERT F. GREEN, M.D.
Fort Wayne

SUBSEQUENT to the launching of Sputnik by the USSR on October 4, 1957, there has been increasing concern with the quality of education in the United States. One problem in particular that has been discussed at length in professional circles and has received considerable attention in the press and other media is the "dropout."

The "dropout" is defined as an individual who terminates his or her education usually prior to the completion of high school.[1]

Much has been said and written concerning the cause of dropouts.[2] In a number of instances, programs have been initiated to combat the problem, or at least the symptoms, in order to reintegrate the lost student into a constructive role in society.

My interest in this subject arose not only as a result of the publicity accompanying various remedies proposed, but also as a result of having my curiosity piqued by patients I saw in consultation or who were referred for evaluation and treatment. In each instance, an educational history was elicited during the routine anamnesis.

This, in conjunction with other segments of the historical profile of the patient, afforded an opportunity for retrospective analysis as to where an illness became overt, and with other factors taken into consideration, what kind of prognosis the patient might have.

I decided to take an arbitrary survey of the patients I have seen. The years selected were 1964 and 1965 and involved 586 patients from Fort Wayne, Ind., and its environs. The city is a metropolitan area in northeastern Indiana consisting of approximately 172,000 people and an equal number of people in the immediate periphery. It is an urban industrial center with approximately 10% of its population being non-Caucasians.

A study of patients admitted to Parkview Hospital who were not psychiatric, pediatric or obstetrical admissions was conducted in January and February of 1967 and included as a comparative group in this report. The total patient profile is listed in Table I.

Since the study is limited to a specific geographical area, comparative figures were obtained from the local public school system. Dr. Dayton Musselman, Director of the Department of Pupil Personnel of the Fort Wayne Community Schools, was contacted and he informed me of a study undertaken by the Fort Wayne Community Schools under his aegis, called "Project Contact."[3] This study involved an evaluation and follow-up of the school dropouts of the academic year 1963-64 by consultations with the dropouts and their families.

The statistics revealed that a total of 561 students, or 4.1% of 13,563 pupils enrolled in grades seven through twelve, were dropouts during the years 1963 and 1964. Ages ranged from 15 to 19 and an IQ rating of below 80 to above 120, with 61.1% having an IQ greater than 90. More importantly, in the opinion of the examiners, "two-thirds of these students were capable of completing high school." However, 86.4% had failing grades. A partial summary of their findings is found in Table II. Other statistics were elicited but, in my opinion, were not germane to this report.

Patient Study

The average age of both male and

female patients in all categories at the time of their dropping out reveal them to be born in the early days of World War II or just prior to America's entry into World War II with the exception of the male jail, court and the female hospital patient groups. These were considerably younger and were obviously reared in a more favorable climate in terms of the general economy.

Historically, this was a time when we were coming out of the depression and the average individual in this group was not enmeshed in the depression as such.

The subjective reasons for dropping out as given by the patients fell into these categories:

1. Economic
2. Not interested
3. Boring

The latter two responses were very frequent when the patient was asked why he dropped out at the particular time he did. Tables III, IV, V, VI and VII reveal the breakdown of the patient groups into their respective diagnostic categories.

Discussion

The question arises as to how many of the dropouts are potential patients or perhaps incipient and possibly insidious cases of a major emotional illness. Is this "dropout" really the first overt manifestation of his or her illness?

Comparison among the three groups reveals a dropout rate of 4.1% in the local community schools vs. a dropout rate ranging from 33% to 100% in the patient group. The second group, the nonpsychiatric admissions to the hospital, shows a statistically significant difference in both female and male dropouts when compared to the hospital psychiatric patients. It was impossible, under the circumstances of the study, to determine how many of the nonpsychiatric patients eventually were referred for psychiatric consultation or transferred to the psychiatric section of the hospital. The study does

TOTAL PATIENT PROFILE

	Male	Female	Total
Hospital Psychiatric Patients	113	245	358
Average Age	40.5	34.5	
High School Graduates	55	115	
% Not Graduating	53.9%	53.1%	
Hospital Nonpsychiatric Patients	285	315	600
Average Age	46	45	
High School Graduates	179	177	
% Not Graduating	37%	44%	
Office Patients	78	77	155
Average Age	41.5	40	
High School Graduates	30	51	
% Not Graduating	61.5%	33.3%	
Jail Patients	18	1	19
Average Age	24	20	
High School Graduates	3	1	
% Not Graduating	83.4%	0%	
Veterans Administration Office Evaluation	14	1	15
Average Age	39.5	28	
High School Graduates	6	1	
% Not Graduating	57.2%	0%	
Social Security Office Evaluation	21	7	28
Average Age	44.5	45	
High School Graduates	10	3	
% Not Graduating	52.4%	57.2%	
Court Evaluation	8	3	11
Average Age	30	49	
High School Graduates	0	2	
% Not Graduating	100%	33.3%	

TABLE I

"PROJECT CONTACT"

A. Immediate reasons given for the dropouts by the school study were:

1.	Behavioral	20.6%
2.	Marriage	11.8%
3.	Pregnancy	12.1%
4.	State institutions	2.9%
5.	Armed Services	9.4%
6.	Employment	14.3%
7.	Illness	5.6%
8.	No specific reason	23.3%

B. Basic Causes:

1.	Physical and emotional disability	12.8%
2.	Mental limitation	6.3%
3.	Home problems	18.4%
4.	Lack of interest in school	46.7%
5.	Cumulative early school problems	5.2%
6.	Not determined	10.5%

C. Subjective Reasons:

1.	Good attitude about school	44.1%
2.	Uninteresting	32.2%
3.	No feeling of belonging	11.5%

TABLE II

DIAGNOSTIC CATEGORIES— OFFICE PATIENTS

Diagnosis	Cases	Percent
Schizophrenia	42	27%
Emotionally Immature	19	12.2
Depressive Reaction	43	27.7
Psychotic Depression	3	2
Agitated Depression	10	6.5
Involutional Depression	12	7.7
Others	26	16.7
TOTAL	155	

TABLE III

DIAGNOSTIC CATEGORIES— HOSPITAL PATIENTS

Diagnosis	Cases	Percent
Schizophrenia	96	26.7%
Emotionally Immature	35	10
Depressive Reaction	90	25.3
Psychotic Depression	15	4.2
Agitated Depression	39	10.8
Involutional Depression	37	10.2
Others	46	12.8
TOTAL	358	

TABLE IV

DIAGNOSTIC CATEGORIES— VETERANS ADMINISTRATION PATIENTS

Diagnosis	Cases	Percent
Schizophrenia	10	50%
Psychotic Depression	1	5
Emotionally Immature	2	10
Depressive Reaction	3	15
Agitated Depression	1	5
Others	3	15
TOTAL	20	

TABLE V

DIAGNOSTIC CATEGORIES— SOCIAL SECURITY PATIENTS

Diagnosis	Cases	Percent
Schizophrenia	17	60.7%
Psychotic Depression	1	3.5
Emotionally Immature	1	3.5
Depressive Reaction	4	14.2
Involutional Depression	2	7.1
Others	3	10.7
TOTAL	28	

TABLE VI

reveal that the patients were in the same grade and age span as the student dropouts although in a different era. What then may we postulate as causes for the dropout?

DIAGNOSTIC CATEGORIES— COURT/JAIL PATIENTS

Diagnosis	Cases	Percent
Schizophrenia	5	16.6%
Emotionally Immature	1	3.3
Depressive Reaction	3	10
Sociopathic Personality	21	70
TOTAL	30	

TABLE VII

We know that psychologically as well as chronologically, the time of dropping out is characterized by conscious and unconscious turmoil in all groups of individuals. This is a period when sexual identification is taking place, when "a feeling of belonging" to a peer group is considered important and where establishing heterosexual relationships is of vital importance to the further development of the individual.

In essence, this is a period of emotional turmoil for the dropout as well as for the non-dropout. Our question is whether or not dropping out is in itself a reaction to the inability to meet this period of turmoil at a satisfactory level. Is dropping out then an ego-defense to the anxiety of adolescence?

If these indications are correct in terms of the subjective as well as the objective findings by the school and patient studies, and in terms of the number and percentage of dropouts, the question arises as to whether or not we should concentrate on the diagnosis and possible treatment of a dropout with more detailed psychological and psychiatric evaluations rather than some immediate attempt in environmental manipulation and/or occupational therapy.

Certainly one would question the advisability and the judiciousness of an attempt at milieu therapy in treat-

ing what may be the beginning of a major emotional illness.

Many other questions arise, but because of the nature of this material they must be left unanswered. Perhaps the link between the hardened criminal and the dropout would not be forged if psychiatric evaluation were available at the time of cessation of school.

It would appear that the distinction between the dropout per se and the evolution of a beginning emotional illness must be delineated for the benefit of the individual in particular and society in general. Perhaps this early evaluation and delineation would allow for a more sound rationale for dealing with dropouts rather than a blanket program predicated on vocational rehabilitation for those who appear to be, at least in retrospect, mentally ill.

It is firmly hoped that further studies and evaluations of these individuals will be conducted to shed a greater light on the emotional components of the dropout.

BIBLIOGRAPHY

1. Gowan, J. C., Demos, G. D.: The Disadvantaged and Potential Dropout, Charles C Thomas, Publisher, Springfield, Ill., 1966, p. 92.
2. Ibid.
3. Musselman, D. L.: Project Contact, Fort Wayne Community Schools, Fort Wayne, Indiana, 1964. ◀

614 W. Berry St.
Fort Wayne 46802

I.U. School of Medicine Postgraduate Courses

(Division of Postgraduate Medical Education)

DATE	COURSE TITLE	LOCATION	COURSE DIRECTOR
Oct. 2	Management af the Enteritides and Other Cammon G. I. Prablems	I. U. M. C.	Philip Christiansen, M.D.
Oct. 2	Emational Prablems in Family Practice	Robert E. Lee Matar Inn, New Albany, Ind.	Daniel H. Cannan, M.D.
Oct. 10	Psychiatry in Everyday Practice	Richmand State Haspital, Richmond, Ind.	David Wynegar, M.D.
Oct. 23	Cammon Psychiatric Disarders	Indiana University, Bloomingtan, Ind.	Eldred Hardtke, M.D.
Oct. 30	Psychiatry in Everyday Practice	Hendricks Caunty Hospital, Danvilie, Ind.	Jahn P. Calhaun, M.D.
Nov. 6	Psychiatric Prablems af Adolescents	Memarial Haspital, Sauth Bend, Ind.	R. Charles Eades, M.D.
Nav. 6	Advances in Infectiaus Disease Management	I. U. M. C.	Arthur White, M.D.
Nov. 13	Practical Office Management af ENT Prablems	I. U. M. C.	David Brawn, M.D.
Nav. 20	Medical Genetics & The Problem af Transplanatian	I. U. M. C.	Danald Merritt, M.D.
Dec. 11	Office Gynecalagy	I. U. M. C.	Carl Huber, M.D.
Jan. 15	Acute Cardialagy	Marion County General Haspital	Charles Fisch, M.D.
Feb. 12	Emational Prablems of Young People	Ball State University, Muncie, Ind.	Wayne G. Pippenger, M.D.
Feb. 12	Madern Therapy af Cancer	I. U. M. C.	Rabert Rahn, M.D.
Feb. 19	Management af Pediatric Handicaps	I. U. M. C.	Marris Green, M.D.
Mar. 5	Therapy af Chronic Obstructive Lung Disease and Branchitis	I. U. M. C.	Ray Behnke, M.D.
Mar. 13/14	Cammunity Neurolagy	I. U. M. C.	Jaseph Green, M.D.
Mar. 19, 20, 21	Electracardiography for Physicians	I. U. M. C.	Danald Clase, M.D.
Mar. 24, 25, 26	Electracardiagraphic Interpretation of Arrhythmia	Marion County General Haspital	Charles Fisch, M.D.
Mar. 26	Ophthalmalagy for the General Practitianer	I. U. M. C.	Fred Wilsan, M.D.
April 2	Management af Cangenital Anomalies af Skin and Saft Tissue	I. U. M. C.	James Bennett, M.D.
Apr. 15, 16, 17, 18	Radiolagy of Trauma	I. U. M. C.	Jahn Campbell, M.D.
Apr. 13-Apr. 27	Anatomical and Clinical Otolaryngalagy	I. U. M. C.	David Brown, M.D.
April 23	Management af Camman Dermatalagic Canditians	Marion Caunty General Haspital	Victor Hackney, M.D
May 13/14	Indiana Multidisciplinary Child Care Canference	Stauffer's Inn	Morris Green, M.D.
May 22	Psychiatry in Everyday Practice	Elks Cauntry Club, Sullivan, Ind.	Betty Dukes, M.D.

Samaritan
Foundation, Inc.

If you . . . or your parents . . . are approaching retirement age, there will be a number of important decisions to be made. These decisions often appear overwhelming to those without experience in counseling and assisting elderly citizens. But to those of us associated with the Samaritan Foundation, Inc., the concerns of the elderly are our concern . . . and our reputation and success is weighed solely by the satisfaction and happiness of the retired residents who make their homes with us.

Starting nearly ten years ago with the Baptist Home in Zionsville, we now operate three beautiful non-denominational retirement apartments in Indiana. The Zionsville apartments, now known as Hoosier Village, are home to 180 men and women. Our Four Seasons Apartments in Columbus and Towne House Apartments in Fort Wayne can accommodate a total of another 240.

If retirement years are facing you or members of your family, why don't you visit one of our Samaritan apartments and see for yourself how happiness and security . . . how both privacy and companionship . . . can be a new and interesting way of life in comfortable, convenient surroundings. See how our facilities complement both the needs of our more active residents as well as those who require extended health care.

If it is not possible for you to visit us, just write to the address shown below and we will send you a full-color brochure picturing our handsome apartments and some of the scenes which represent "home" to many of Indiana's happiest retirees.

DR. LOREN E. MOORE, *President*
SAMARITAN FOUNDATION, INC.
Baptist Homes and Hospitals, Inc.

For free brochure write to:
Samaritan Foundation, Inc.
5300 West 96th Street
Indianapolis, Indiana 46077

The Towne House

FORT WAYNE, INDIANA

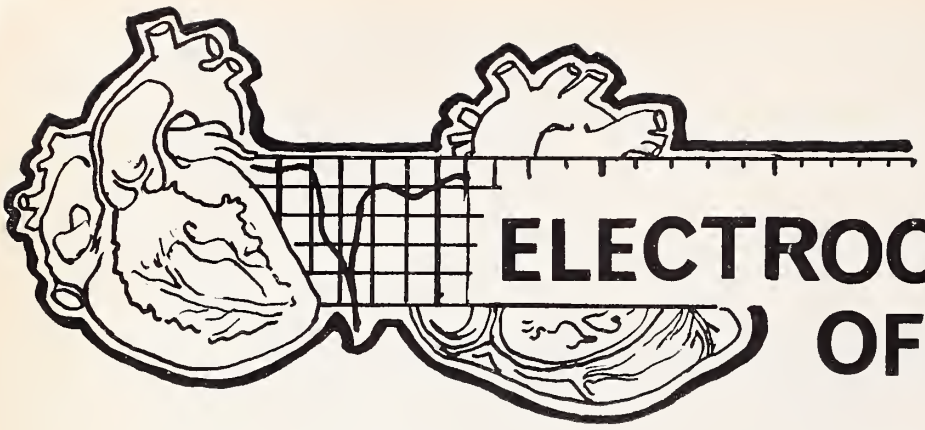
HOOSIER VILLAGE

BAPTIST HOME

ZIONSVILLE, INDIANA

The Four Seasons

COLUMBUS, INDIANA



ELECTROCARDIOGRAM OF THE MONTH

CHARLES FISCH, M.D.
Indianapolis

THE accompanying figure is a composite of precordial leads of four different patients with T wave abnormalities. After you have jotted down your impression of the etiological diagnosis for each of the four cases, please turn the page upside down for the answer.

Tracings with abnormal T waves were presented in the July and August, 1968 issues of the *JISMA*.

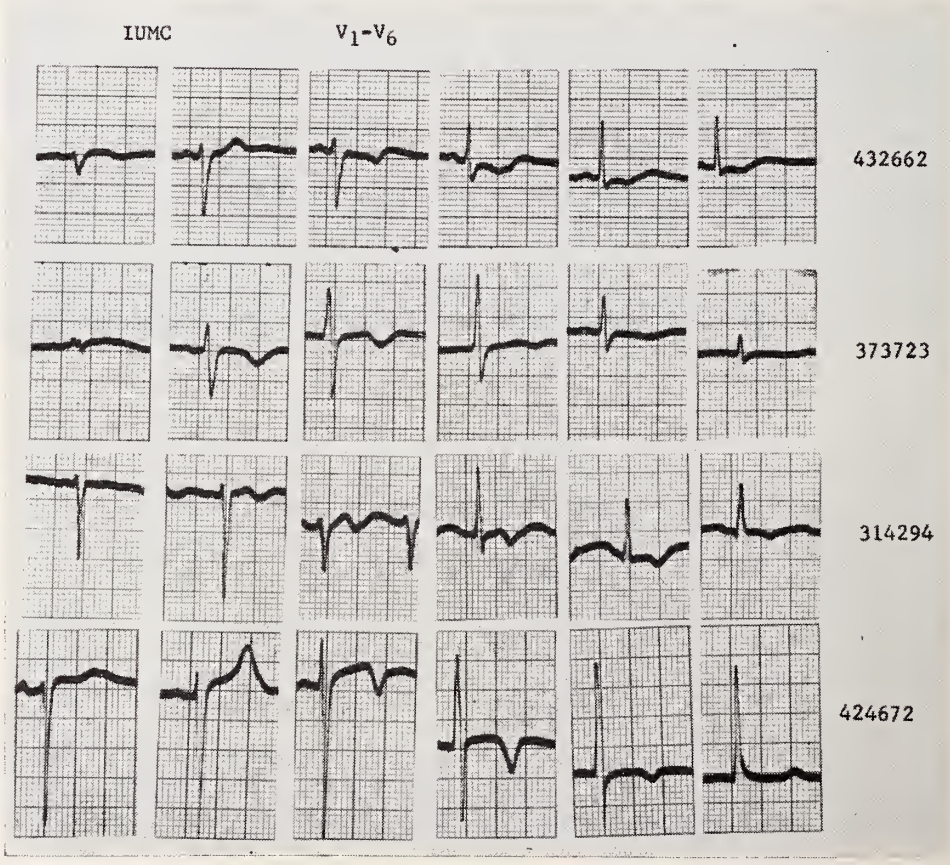


FIGURE 1
432662 — Alkalosis
373723 — Hypokalemia
314294 — Hypercalcemia
424672 — Bullet lodged in the myocardium

* From the Krannert Institute of Cardiology, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.

Let's be specific about Campbell's Soups...
and *reducing diets*

There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

THE RESTLESS DUODENUM...

DUODENUM—(Conventional X-ray) The restless duodenum makes radiographic diagnosis difficult, uncertain and often unproductive. Is this duodenum normal?

Pro-Banthine®
brand of
propantheline bromide

For fifteen years Pro-Banthine has been the most widely used anticholinergic agent in disorders of gastrointestinal motility and gastric hypersecretion. More recently Pro-Banthine has reestablished its pharmacologic effectiveness in facilitating diagnostic procedures using intragastric fibroscopy and hypotonic roentgenography.

How the X-rays were taken

In the hypotonic duodenograph[1,2] reproduced above, the gastrointestinal tract was relaxed with Pro-Banthine. The duodenum was intubated. Pro-Banthine in a dose of 60 mg. intramuscularly was used to assure prompt aperistalsis, and double-contrast visualization was achieved with ordinary barium and air.

The same pharmacologic efficiency has proved of pronounced value in such conditions as: *peptic ulcer, pylorospasm, biliary dyskinesia, functional hypermotility and irritable colon.*

...AT REST

SAME DUODENUM—(Hypotonic X-ray) Pro-Banthine-induced duodenal calm permits full anatomic appraisal in the same patient. Duodenal normality is now evident.

calms the gastrointestinal tract

Contraindications: Glaucoma; severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly males with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

(1) Bilbao, M. K.; Frische, L. H.; Rösch, J., and Dotter, C. T.: Hypotonic Duodenography, Scientific Exhibit, Radiological Society of North America, Chicago, Nov. 27—Dec. 2, 1966.

(2) Bilbao, M. K.; Frische, L. H.; Dotter, C. T., and Rösch, J.: Hypotonic Duodenography, Radiology 89:438-443 (Sept.) 1967.

See also: Liotta, D.: Pour le diagnostic des tumeurs du pancréas: La duodénographie hypotonique. Lyon chir. 50:445-460 (May-June) 1955.

SEARLE *Research in the Service of Medicine*

on call...
Keflin®
Sodium
Cephalothin
4 Gm.
SODIUM
CEPHALOTHIN
KEFLIN®
Lilly
Eli Lilly and Company
Indianapolis, Indiana 46206
800486

X-RAY CONFERENCE

Blastomycosis Osteomyelitis

*JOHN L. GREER, M.D.**
*ERICH K. LANG, M.D.***
Shreveport, La.

A 28-year-old colored male was admitted to the Confederate Memorial Medical Center with an eight month history of right shoulder and left knee pain. The patient's private physician had attempted drainage of the swelling over the right shoulder and a draining sinus resulted, despite massive and prolonged antibiotic therapy. Swelling of the left knee and pain in the left hip had developed during the three months prior to admission, the patient had lost 33 pounds and was hospitalized with a diagnosis of pneumonia.

The patient appeared cachectic and was febrile. Roentgenographic examinations revealed osteolytic lesions in the lateral aspect of the right clavicle, the proximal right humerus and the left femoral neck, as well as the supracondylar area of the left femur (Figure 1). The clearly defined osteolytic lesion suggested the possibility of blastomycosis osteomyelitis. A chest roentgenogram demon-

* Instructor, Department of Radiology, L. S. U. School of Medicine, Confederate Memorial Medical Center, Shreveport 71106.

** Professor and Chairman, Department of Radiology, L. S. U. School of Medicine, Confederate Memorial Medical Center, Shreveport 71106.

FIGURE 1

NOTE the characteristic lytic lesions in the neck of the left femur and the right intercondylar region of the femur. A significant absence of surrounding sclerosis in the presence of marked destruction suggests the possibility of blastomycosis.

strated mediastinal adenopathy. Skin tests for blastomycosis were negative.

Incision and drainage of the swollen left knee was carried out and a large amount of purulent material was drained. A biopsy of the lesion of the distal left femur and culture of the fluid demonstrated budding yeast and the culture grew out Blastomyces dermatitidis. Therapy was begun with 2-hydroxystilbamidine, however, severe pain and febrile reaction necessitated discontinuation of this drug. Amphotericin B therapy was instituted and continued with no significant reaction. Over the next two months, the osseous lesions began to sclerose. The latest set of follow-up roentgenograms, obtained eight months after initial therapy, showed no evidence of active osseous lesions.

Discussion

The roentgenographic appearance of osseous lesions of blastomycosis is similar to that of any chronic pyogenic osteomyelitis. The salient point differentiating blastomycosis appears to be a significant lack of surrounding sclerosis with marked destruction. The diagnosis of blastomycosis, while suggested on the basis of marked disruption and lack of sclerosis, has to be confirmed by bacteriologic studies. The fulminating course of blastomycosis osteomyelitis is best demonstrated in the spinal column. Massive involvement of the vertebral bodies and destruction of the intervertebral discs is a salient feature.

The extension of blastomycosis to the osseous system may be by direct extension of inflammatory processes of the skin or occasionally by systemic blastomycosis causing metastatic lesions on the basis of hematogenous spread of the organism.

The healing phase is characterized by a gradual filling of the lytic lesion and a homogenous sclerosis of the entire lesion, rather than just the margin. ◄

From *The Journal* 50 Years Ago

. . . It was formerly thought that micro-organisms did not enter healthy sinuses during life. Such was the belief of Torne (quoting from Skillern) after demonstrating that healthy sinuses of cadavers which had been dead for two hours were without exception sterile. His later researches proved conclusively that such was not the case. Physiologists have proven that the sinuses are aerated during every respiration, and that during these respirations micro-organisms will find their way into and become lodged in the mucosa. If the sinus mucosa is healthy the presence of these foreign bodies stimulate the cilia to greater activity and are expelled.

The sinuses are therefore protected in two ways: (1) By the action of the cilia of the mucosa which continually wave toward the sinus ostium, and (2) by the secretions of the glands situated in the mucosa which possesses a decided inhibitory power to the further growth of the invading organism.

Both of these conditions must be overcome before infection of the sinuses can occur. This will account for the comparatively infrequent infection of the sinuses as compared with the number of infected, otherwise healthy individuals, during these epidemics. Of course, it must be admitted that sinus infections can and do occur through lymph and blood streams in systemic streptococcus infections, but these are not the class of cases under consideration. In acute exacerbations of chronic sinusitis there is probably a fresh infection . . . . W. A. Hollis, M.D., Hartford City, "Epidemic Streptococcus Infection of the Nose and Throat Clinically Considered," *JISMA*, September, 1918.

The billion dollar bank in Indiana

On June 30, 1968, The Indiana National Bank of Indianapolis became a billion dollar bank, an achievement of fewer than 60 of the more than 14,000 commercial banks in the United States.

It's fitting this milestone comes at a time when plans are being made to "top out" the 37-story Indiana National Bank Tower, our new headquarters office scheduled for completion late next year. For as the Tower is a symbol of the revitalization of downtown Indianapolis, this new plateau of bank growth is a symbol of the dynamic thrust forward of an economy which has given our community the title of "City on the Move."

For 134 years, Indiana National has been a leader among banks in meeting the many and varied requirements of our quarter-million customers—an awesome responsibility to be sure—but a confidence we mean to keep!

INDIANA NATIONAL
THE BANK IN INDIANA

Photograph of downtown Indianapolis as it will appear upon completion of Indiana's tallest building, the 37-story Indiana National Bank Tower (upper left), the 20-story Indianapolis Hilton Hotel (left center), and the 18-story Blue Cross—Blue Shield Building (bottom center).

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 1802 North Illinois Street, Indianapolis, Ind. 46202.

Associate Editors: A. W. Cavins, M.D., 221 South Sixth Street, Terre Haute; Lall G. Montgomery, M.D., Ball Memorial Hospital, Muncie; David A. Bickel, M.D., 515 Odd Fellows Building, South Bend; Samuel R. Mercer, M.D., 702 Medical Center Bldg., Fort Wayne; I. W. Wilkens, M.D., 1743 Shelby St., Indianapolis.

Editorial Board: Term Expires

Alvin J. Haley, M.D., Fort Wayne . . . . Dec. 31, 1968
Wei-Ping Loh, M.D., Gary . . . . . Dec. 31, 1968
Jack W. Hickman, M.D., Indianapolis . . . Dec. 31, 1969
Frank H. Coble, M.D., Richmond . . . . . Dec. 31, 1969
Jene R. Bennett, M.D., South Bend . . . . Dec. 31, 1970
W. D. Snively, Jr., M.D., Evansville . . . . Dec. 31, 1970

Assistant Editor: Jackie Freers Stahl
Business Manager: James A. Waggener
3935 N. Meridian, Indianapolis, Indiana 46208.

The Undiagnosed Diabetic

UNDIAGNOSED diabetics are not being located fast enough.

Dr. Glen McDonald, Chief of the Diabetes and Arthritis Control Program of the U. S. Public Health Service, in an editorial in the first issue of the new *Disease Detection Newsletter*, is worried about the slowness with which diabetics are converted from "unknown" to "known."

Last year, he reports, only 7,700 new diabetics were discovered out of 800,000 who took blood sugar tests. It is estimated that there are 1.6 million undiagnosed cases in the United States, although no one will be sure how many there are until they have all been located.

Dr. McDonald thinks that the tests are given too often to everyone who came to be tested. He thinks that the tests should all be limited to the high-risk people—those most likely to have diabetes—in general, those over 40 who are overweight and related to a diabetic.

This is reminiscent of Joslin's remark: "The unknown diabetic is not a mysterious person; he or she is usually the overweight relative of a known diabetic."

Dr. McDonald also thinks that the answer is to increase community support and participation in the detection programs. The *Disease Detection Newsletter* is a public-service information source which is dedicated to the communication of facts and ideas about disease detection. It and *Why Wait?*, which encourages year-round detection programs, are both supported by Ames Company, Division of Miles Laboratories of Elkhart.

Diabetes detection programs are being conducted year-round in the state of Delaware, and the communities of Peoria, Illinois; Dixon, Illinois; Jacksonville, Florida and Long Beach, California. Many more communities are going to start soon.

"Why Wait" is a shortened form for the slogan: Why wait for the symtoms or complications of diabetes to strike? Get tested now.

More information is available by writing to Disease Detection Information Bureau, 3553 W. Peterson Ave., Chicago 60645.

The Secretary's Misconception

THE old grouch stormed into the staff room yesterday. "We've got enough trouble trying to improve medical care as it is, without having the new Secretary of HEW perpetuating misconceptions," he fumed, to no one in particular. "I've heard many accusations about Mr. Cohen in the past from physicians," I said, "but would you care to be a bit more specific?"

This was all the invitation the old grouch needed. He informed me that Mr. Cohen had stated, during his testimony before the Senate subcommittee that was advising and consenting to his appointment as Secretary, that the principle way by which this country could reduce health costs would be to turn out more physicians. This seemed to follow the basic law of supply and demand that I had learned in my high school economics course, so I wondered what the old grouch found so objectionable. "Turn your brain off for a second, and then restart it," he advised. "Do you really believe that increasing the number of physicians by any number that is within feasible limits would cause a reduction of physician's fees?" he queried. Actually, as I thought about it in that light, I had to agree that physician's fees would not decrease, unless the number of physicians was increased fantastically—far beyond the capabilities of our medical schools.

This, even though the logic was perfectly clear, was difficult for me to accept, and I balked at it. Even

harder to accept was the immediately apparent corollary that the only way to reduce medical expenditures would be perforce, to reduce the number of practitioners. "Of course," said the old grouch, "now you're realizing that the Secretary is going to have to discard some of these standard misconceptions, and to get some better idea in mind of his goals. He had better get it clear in his mind whether he is going to talk about providing medical care or medical costs. If he is going to speak about them concomitantly, he'd better get their true relationships straight."

I felt compelled to tell him that Secretary Cohen was not alone in these beliefs. Within recent months I heard or read similar thoughts by university, medical school and foundation spokesmen. This didn't surprise him at all, because he just countered with the observation that misconceptions perpetuate themselves with ease. "For example, another misconception concerns total medical expenditures . . . ," but at that time he was paged by the operator and had to leave, but not without promising me to finish his sentence the next time he saw me.—J.W.H.

Guest Editorials

Charge to Interns*

DONALD E. STEPHENS, M.D.
Indianapolis

IN searching for a topic for discussion this evening, I asked myself what would be appropriate on an occasion such as this. Here, we have gathered together to acknowledge the accomplishments of a group of fine young men and women of medicine, many of whom will be leaving this medical institution of higher learning to enter into the practice of their art.

Since I have reached the age where reflection on the past is an occasional indulgence, I felt that I might be bold enough to suggest to all of you the following recommendations that you might adopt to bring you success and fulfillment in this new adventure on which you are about to embark.

Early in my medical training, a dear friend, who had been quite successful in his business as a paper manufacturer, told me as we were philosophizing one day—"Steve, you take care of your practice when you become a doctor, and your practice will take care of you." I am sure that this was good advice and it served as a guiding force to me in the early days of my practice. However, I soon realized that one needs more than this to keep one's enthusiasm glowing for the practice of medicine during some of its more trying days.

With this in mind, I have made a list of character traits that I believe one should possess if he or she is to enjoy success to its fullest.

1st. Have the *courage* to stand by your convictions.

2nd. Be *honest* in all your endeavors.

3rd. Be *resolute* in pursuing your objectives.

4th. Be *interested* in the problems of your fellow man.

5th. *Serve* in community activities and programs.

6th. Be *trustworthy* in all of your performances.

7th. Have *integrity* that is unchallengable.

8th. Be *ambitious* for your family, religion and community.

9th. Be *noble* in character.

Put the "C" of courage, the "H" of honesty, the "R" of resolute, the "I" of interest, the "S" of service, the "T" of trustworthy, the "I" of integrity, the "A" of ambition and the "N" of noble all together and they spell Christian, a philosophy which has proved its success.

Best of fortune to all of you is extended by the medical staff of Methodist Hospital. Thank you.

* Charge to graduating class of interns, Methodist Hospital Graduate Medical Center, Indianapolis, June, 1968.

FLEX

THE first Federation Licensing Examination (FLEX), which has been in the development stage for more than seven years, will be administered June 18-20.

About 2,500 applicants are expected to be examined during 1968. This is the first time that a single examination for medical licensure has been prepared and is being administered for licensure in more than one state. The number of states participating is not known at this writing.

The Examining Institute Committee of The Federation of State Medical Boards of the United States was responsible for researching and developing the examination, and the National Board of Medical Examiners served in an advisory capacity and provided the questions.

In years past many physicians wishing to relocate and practice medicine in another state were required to be re-examined by that state. This has proved to be a constant source of annoyance. It is hoped that FLEX will not only correct that and similar problems, but at the same time achieve uniformity in licensing examinations, equivalent levels in the examinations, and improvement in the quality of examinations.

"Eligibility for the examination will be limited to those who have completed or nearly completed one year of internship or other graduate training as approved by the state board with the provision that the requirement of one year internship or graduate training may be waived in 1968 only, in any state where circumstances require. It is conceivable that the period of this waiver might need to be extended," the committee stated.

The 3-day, 21½-hour test, which is administered by members of the state boards, will be repeated December 10, 11, and 12. For security [illegible] it has been decided to conduct it on the same three days throughout the

United States. Scores will be reported directly to the participating states, which will then have the option of interpreting them as they see fit.

This is a welcome cooperative endeavor.—*Rhode Island Medical Journal* **LI:460, No. 7, July, 1968. Reprinted with permission.**

Generic Politicians

THE increase in medical knowledge has equaled the precipitous rise of its counterparts in other sciences. Yet, a hue and cry have been raised in governmental circles, asserting that the progress in medicine has been made at unjustifiable expense to the patient's pocketbook.

In recent months, some of the members of that most august body in the United States, the Senate, have seen fit to question the value of proprietary designations in prescription writing. They want generic dispensing.

This is cant of the highest order. Does not every member of the Senate most carefully label himself as a "D" or an "R" to designate what he is believed to stand for?

Suppose there were to be a hearing on the use of generic terms in politics! How could one party or the other assume that all donors to testimonial dinners or to campaign drives had no hope for personal gain? Of course, dishonesty is an unuttered word in Congress, except for the members of the opposition.

Suppose that a candidate had to run for Congressional office with no official political designation! One could only hope to be able to hide from the clamor that would be raised by the contestants. How would they identify themselves? What would their fate be on a ballot with the simple generic designation of "politician"? Wouldn't it be a jolly election if the candidates ran on their own virtues and achievements? Will that day ever come? If the "pols" think there'll be even a tiny chance of this, they'll jump on the proprietary bandwagon. After all, labels do mean something.—**Carl Bearse, M.D., Editor,** *Massachusetts Physician* **27:51, March, 1968.**

Editorial Notes . . .

The American Association for Accreditation of Laboratory Animal Care recently issued its first list of fully accredited facilities. The national list includes 99 laboratories, two of which are in Indiana. The AAALAC was founded in 1965 by 16 organizations interested in scientific research. Its function is to maintain high standards of care for laboratory animals and to provide a means of self-regulation. The list includes four universities; 23 medical schools; four dental schools; five medical and dental schools with combined facilities; two veterinary medical schools; one school of pharmacy; one school of public health; 16 government facilities; nine hospitals; four private research laboratories; 27 pharmaceutical manufacturers and three laboratory animal breeders.

The National Library of Medicine is expanding and upgrading its system for automated information retrieval system usually referred to as MEDLARS. MEDLARS II will be the most sophisticated total data management system yet developed for today's third generation computers. The system will control the flow of information from the time the material is ordered from the publisher, through cataloguing and indexing, to its appearance in a library publication or in response to a search request from an individual.

Indiana hospitals have filled 132 of their internships for this year. Last year the total was 111. The increase is a solid 18%. Also this year, 103 graduates of I.U. School of Medicine are interning in nine hospitals in five cities in Indiana as contrasted with the 81 I.U. graduates who interned last year in only two Indiana cities.

The Atomic Energy Commission's truck-mounted cesium irradiator will be used to irradiate 10,000 pounds of weevil-infested sweet potatoes in Louisiana. The radiation dosage is adjusted, not to kill the weevils, but to render them sterile. They are later released in a nine-to-one ratio of sterile to fertile male weevils. The eventual result is expected to be that the sterile males will compete in the mating process without issue, thus reducing the weevil population. Several million sterile weevils may be produced in one week's time. A similar process was used in 1958 and 1959 to rid livestock in the southeastern U.S. of the screwworm fly. Fifty million sterile flies were released weekly and the insect was rapidly eliminated because, even though eggs were laid in normal numbers, none was hatched.

Disease Detection Information Bureau (DDIB) has been formed in Chicago. It is a new public service organization, supported by Ames Company of Elkhart, as a source for informational and educational materials in a number of different disease conditions which can be readily detected through medically-approved screening programs. DDIB will serve as national headquarters for Why Wait? diabetes detection programs, now underway in several states and cities and soon to be launched in many other cities.

Some modern drugs should be dispensed with written statements of caution to prevent actions and behavior on the part of the patient incompatable with the pharmacological effects. William G. Tarrant, Jr., writing in *Virginia Medical Monthly,* suggests that labels such as "Don't drive an automobile or operate machinery"—"Alcohol should be avoided"—"Avoid excessive sunlight"—and other similar instructions might properly be a standard entry on the prescription label. ◄

President's Page

As this, one of the last of your current president's messages, is written, most of us have just witnessed and heard the proceedings of both of this country's major political parties' conventions. We are familiar with the efforts of both parties to present to the American people platforms designed to express the desires of the greatest number of voters in the next national election.

It is my belief that unanimous approval of the physician in the state and in the entire nation could be obtained in support of one platform plank for our profession—that we will devote our sincere effort to constantly improve the quality and the quantity of medical care for the American people and the methods of its delivery to every segment of our population.

I believe also that the citizens of our country will give wholehearted support to this expression of our aim and give us their help if we will but exhibit intelligence enough to present a united front and strive for better communication with the people. There is nothing new in this idea. It has, I am sure, been expressed more eloquently by many others. However, I am convinced that we have little time remaining to convince the public and our lawmakers of the fact that the experience of doctors and their active cooperation must be obtained if American medicine is to continue to be one of the world leaders in providing and distributing the best in the way of health care in all of its aspects to all of our people.

We can succeed, but only if each of us actively participates in the determination of our policies and then vigorously supports these policies. I urge each of you to help elect your most qualified doctors—those who are interested and who will work to be the officers of your county and district societies, for strong leadership is an absolute necessity.

To do less than this is to deny our successors the tremendous heritage which we inherited from our predecessors.

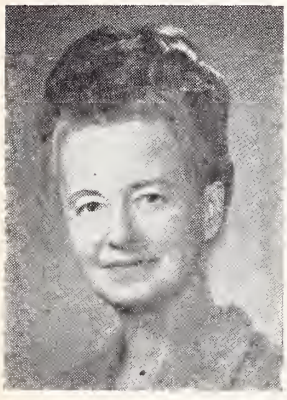
G. O. Larson M.D.

The Woman's Auxiliary

REPORTS TO ISMA

Have you recently been asked to talk to a group of community leaders concerning the national health menace of teen-age venereal disease . . . and turned down the request because you just did not have time to research the matter?

Next time, check with your wife about the Woman's Auxiliary "package program."



Do you need to stimulate concern among organizations and individuals in your area for the emotional well-being of children? Have you seen the film, "The Time for Growing," that tells how early signs of emotional difficulties may be detected? Would it be of help in your presentation of the problem?

Check with your wife . . . the Woman's Auxiliary has a "package program."

Are there elderly citizens in your community who need occasional aids with everyday living? Do you need a homemaker service to help during those first difficult days when an elderly patient returns home from the hospital? Where do you find emergency housekeepers for that young family whose mother is suddenly hospitalized?

Check with your wife . . . the Woman's Auxiliary has a "package program" in this field.

Are you struggling to educate parents to immunize their children? Do you need help in bringing to public attention the individual and community responsibilities in communicable disease control?

Check with your wife about the Woman's Auxiliary "package program."

Do you wish that you had more time to counsel young people who seek advice on entering the health careers field? Do you need to interest the PTA and other groups in a system to protect children going to and coming from school? Does your community know the value of health education in the physical, mental and social well-being of youth?

Check with your wife . . . the Woman's Auxiliary has a "package program" in each of these areas.

What *is* a package program? It is a folder of resource material prepared at the national level to enable your county auxiliary to sponsor a timely health education program for community groups. Included in each package is a procedure guide, a fact sheet, a question-and-answer sheet for audience participation, a source list of recommended films and an authoritative speech on the given subject.

Check with your wife . . . the Woman's Auxiliary is waiting and willing "to assist the medical society in its program for the advancement of medicine and public health." These package programs are exciting and timely.

Who is the president of your Woman's Auxiliary . . . how do you get the girls involved?

Check with your wife . . . she *is* an auxiliary member, isn't she?

Betty Kephart

119th
Annual Convention

INDIANA STATE MEDICAL ASSOCIATION

October 15, 16, 17 and 18, 1968
All Events on Eastern Standard Time
Scottish Rite Cathedral, Shrine Club and
Chamber of Commerce Building, Fort Wayne

Complete Program and Annual Reports on Following Pages

September 1968

CONVENTION SECTION
Table of Contents

CONVENTION ISSUE (begins) 1235

OFFICIAL CALL TO THE HOUSE OF DELEGATES 1237

HOUSE OF DELEGATES 1238

1967-68 ISMA OFFICERS 1241
- **Past Presidents** 1241
- **Officers** 1241
- **Councilors** 1241
- **Delegates to AMA** 1241

50-YEAR CLUB, 1968 1241

REFERENCE COMMITTEES 1241

OFFICERS OF THE ISMA 1242

- **The Journal** 1244
- **Section Officers** 1245

PROGRAM FOR THE 119th ANNUAL ISMA CONVENTION 1249
- **Auxiliary Program** 1256

CONVENTION ARRANGEMENTS COMMITTEES 1256

REPORTS OF OFFICERS 1257

- **Executive Secretary** 1257
- **Treasurer** 1257
- **Chairman of the Council** 1261

District Councilors 1262
- First Councilor District 1262
- Second Councilor District 1262
- Third Councilor District 1262
- Fourth Councilor District 1263
- Fifth Councilor District 1263
- Sixth Councilor District 1263
- Seventh Councilor District 1263
- Eighth Councilor District 1264
- Ninth Councilor District (no report)
- Tenth Councilor District 1264
- Eleventh Councilor District (no report)
- Twelfth Councilor District 1264
- Thirteenth Councilor District 1265

Editor of The Journal 1265

Delegates to AMA 1265

REPORTS OF COMMITTEES:
- **Executive** 1268
  - Medical Defense 1268
  - Membership Report 1268
  - The Journal Advertising 1268
- **Grievance** 1269
- **Student Loan** 1269
- **Future Planning** 1269
- **Medical-Legal Review** (no report)
- **Building** 1270

REPORTS OF COMMISSIONS:
- **Constitution and Bylaws** 1271
- **Legislation** 1271
- **Public Information** 1271
- **Governmental Medical Services** 1272
- **Public Health** 1273
- **Voluntary Health Agencies** 1274
- **Medical Economics and Insurance** (no report)
- **Inter-Professional Relations** 1275
- **Medical Education and Licensure** 1275
- **Special Activities** 1276
- **Aging** 1276

RESOLUTIONS 1278

SCIENTIFIC EXHIBITS 1282

TECHNICAL EXHIBITORS 1285

Official Call to the House of Delegates

The next annual session of the Indiana State Medical Association will be held at the Scottish Rite Cathedral, Fort Wayne, Indiana, October 15, 16, 17 and 18, 1968.

The House of Delegates will be constituted as follows: Marion County, 22 delegates; Lake County, nine delegates; Allen County, six delegates; St. Joseph and Vanderburgh county societies, each five delegates; Delaware-Blackford and Tippecanoe county societies, each three delegates; Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Harrison-Crawford, Jackson-Jennings, Jefferson-Switzerland, LaPorte, Madison, Owen-Monroe, Parke, Vermillion, Vigo and Wayne-Union county societies, each two delegates; the other 57 county societies, each one delegate; 13 councilors, and the ex-presidents, namely, Herman M. Baker, Karl R. Ruddell, M. A. Austin, Paul D. Crimm, W. Harry Howard, Walter U. Kennedy, M. C. Topping, Kenneth L. Olson, Earl W. Mericle, Guy A. Owsley, Maurice E. Glock, Donald E. Wood, Joseph M. Black, Kenneth O. Neumann and Eugene S. Rifner, and ex-officio, the president, president-elect, executive secretary and the treasurer of the association, and the delegates to the American Medical Association, all without power to vote, except in the case of a tie vote, when the president shall cast the deciding vote.

All delegates have been certified by their county medical societies. No delegate will be seated unless wearing the official badge.

The House of Delegates will convene promptly at 2:00 p.m., Tuesday, October 15, 1968, in the Auditorium (Anthony Wayne Room), second floor, Chamber of Commerce Building, and again at 9:00 a.m., Friday, October 18, 1968, in the Parlors, Women's Club.

The order of business will be as follows:

1. Call to order by the president.
2. Invocation.
3. Roll call and seating of qualified delegates.
4. Tribute to members of House who have died since the 1967 session.
5. Reading of the minutes of previous meetings.
6. Introduction of guests.
7. Appointment of Reference Committees and assignment of meeting rooms.
8. Unfinished business.
9. Address of president-elect.
10. Report of president of the Woman's Auxiliary.
11. Report of Indiana Chapter Student AMA.
12. Report by president of Blue Shield.
13. Report of executive secretary.
14. Report of treasurer.
15. Report of the chairman of the Council.
16. Reports of councilors.
17. Report of *Journal* editor.
18. AMA Delegates' report.
19. Report of State Board of Medical Registration and Examination.
20. Reports of committees and commissions.

    COMMITTEES:
    (1) Executive
    (2) Grievance
    (3) Student Loan
    (4) Medical-Legal Review
    (5) Building
    (6) Future Planning

    COMMISSIONS:
    (1) Convention Arrangements
    (2) Constitution and Bylaws
    (3) Legislation
    (4) Public Information
    (5) Governmental Medical Services
    (6) Public Health
    (7) Voluntary Health Agencies
    (8) Inter-Professional Relations
    (9) Medical Economics and Insurance
    (10) Medical Education and Licensure
    (11) Special Activities
    (12) Aging
21. New Business
    (1) Resolutions

The election of officers will be the first order of business at the second meeting of the House of Delegates. In addition to the regular officers, the terms of the following officers expire December 31, 1968, and their successors must be elected at the session: delegates to the American Medical Association to succeed Harold C. Ochsner, Indianapolis; Eugene F. Senseny, Fort Wayne; and Frank H. Green, Rushville; alternate delegates to succeed Don E. Wood, Indianapolis; Robert M. Brown, Marion; and Kenneth O. Neumann, Lafayette.

Delegates from the First, Fourth, Seventh, Tenth and Thirteenth Districts are reminded that the terms of their councilors will expire October 18, 1968, and new councilors should be elected to succeed the following:

First District—Gilbert M. Wilhelmus, Evansville
Fourth District—Robert M. Reid, Columbus
Seventh District—Albert M. Donato, Indianapolis
Tenth District—Lowell H. Steen, Hammond
Thirteenth District—Otis R. Bowen, Bremen

Some of these elections already may have been held, but they should be reported to the House of Delegates at this session for confirmation.

JAMES A. WAGGENER, *Executive Secretary*

HOUSE OF DELEGATES

Indiana State Medical Association

Fort Wayne—October 15, 16, 17 and 18, 1968

County and Delegates	Alternates
ADAMS (1)	
Norman E. Beaver, Berne	
ALLEN (6)	
Jerald L. Andrew, Fort Wayne	Fred W. Dahling, New Haven
W. Lloyd Bridges, Fort Wayne	Kenneth W. Klooze, Ft. Wayne
John S. Farquhar, Fort Wayne	William C. Ashman, Ft. Wayne
Charles H. Aust, Fort Wayne	Herbert K. Acker, Ft. Wayne
Richard B. Juergens, Fort Wayne	James P. Scudder, Ft. Wayne
Edwin E. Stumpf, New Haven	Kenneth F. Isenogle, Ft. Wayne
BARTHOLOMEW-BROWN (2)	
Walter Able, Columbus	
Robert Seibel, Nashville	
BENTON (1)	
Thomas J. Stolz, West Lafayette	Virgil Scheurich, Oxford
BOONE (1)	
Thornton D. Perkins, Lebanon	
CARROLL (1)	
T. Neal Petry, Delphi	Marilyn L. Wagoner, Burlington
CASS (1)	
Donald K. Winter, Logansport	R. H. Maschmeyer, Logansport
CLARK (1)	
Eli Goodman Charlestown	
CLAY (1)	
Stanley Froderman, Brazil	Everett Conrad, Brazil
CLINTON (1)	
Robert A. Hedgcock, Frankfort	Charles Bush, Kirklin
DAVIESS-MARTIN (2)	
Robert Rang, Washington	Marshall H. Seat, Washington
E. Briscoe Lett, Loogootee	Robert Chattin, Loogootee
DEARBORN-OHIO (2)	
Leslie M. Baker, Aurora	Frank L. Frable, Lawrenceburg
Gordon S. Fessler, Rising Sun	
DECATUR (1)	
Robert A. Porter, Westport	William Shaffer, Greensburg
DE KALB (1)	

County and Delegates	Alternates
DELAWARE-BLACKFORD (3)	
Thomas M. Brown, Muncie	Jack L. Alexander, Muncie
Glynn Rivers, Muncie	Ross Egger, Middletown
Richard Ingram, Montpelier	Paul Burns, Montpelier
DUBOIS (1)	
Allen D. Scales, Huntingburg	Francis Gootee, Jasper
ELKHART (2)	
James D. Finfrock, Elkhart	Patrick Campbell, Elkhart
Thomas A. Elliott, Elkhart	Myron S. Kennedy, Goshen
FAYETTE-FRANKLIN (2)	
W. F. Kerrigan, Connersville	A. M. Hudson, Connersville
Perry Seal, Brookville	Elmer Peters, Brookville
FLOYD (1)	
Irvin S. Sonne, New Albany	Marshall Buchman, New Albany
FOUNTAIN-WARREN (2)	
Max N. Hoffman, Covington	Lowell R. Stephens, Covington
William A. Ringer, Williamsport	Carl Nelson, West Lebanon
FULTON (1)	
D. K. Stinson, Rochester	F. Richard Walton, Rochester
GIBSON (1)	
R. E. Weitzel, Princeton	James F. Peck, Princeton
GRANT (1)	
Robert M. Brown, Marion	Barton T. Smith, Marion
GREENE (1)	
Sam Rotman, Jasonville	John Woner, Linton
HAMILTON (1)	
Joe R. Lloyd, Noblesville	
HANCOCK (1)	
W. H. Endicott, Greenfield	Bob R. Cagle, New Palestine

County and Delegates	Alternates
HARRISON-CRAWFORD (2)	
Carl Dillman, Corydon	David Dukes, Corydon
Jesse Benz, Marengo	
HENDRICKS (1)	
M. O. Scamahorn, Pittsboro	Elmer Koch, Danville
HENRY (1)	
Kenneth G. Hill, New Castle	David R. Cain, New Castle
HOWARD (1)	
Warren McClure, Kokomo	Richard W. Halfast, Kokomo
HUNTINGTON (1)	
Richard W. Wagner, Huntington	Richard Gill, Huntington
JACKSON-JENNINGS (2)	
Harry Baxter, Seymour	William Scharbrough, Ewing
Forrest D. Ellis, North Vernon	William Johnson, North Vernon
JASPER (1)	
Kenneth R. Ockermann, Rensselaer	E. R. Beaver, Rensselaer
JAY (1)	
J. S. Fitzpatrick, Portland	William Cripe, Portland
JEFFERSON-SWITZERLAND (2)	
Howard Jackson, Madison	Robert Johnson, Madison
Noel Graves, Vevay	
JOHNSON (1)	
Joseph W. Young, Greenwood	Joseph F. Ferrara, Franklin
KNOX (1)	
Herbert O. Chattin, Vincennes	Louie O. Dayson, Vincennes
KOSCIUSKO (1)	
William Cron, Warsaw	
LA GRANGE (1)	
LAKE (9)	
William G. Grosso, East Chicago	Charles T. Disney, Gary
Jacob Pruitt, Gary	Daniel T. Ramker, Hammond
Walfred Nelson, Gary	Lee Trachtenberg, Munster
Nicholas Egnatz, Hammond	Robert A. Church, Munster
Philip J. Rosenbloom, Gary	Rodolfo Madlang, Munster
T. C. Tyrrell, Calumet City, Ill.	Joseph J. Sala, Gary
J. E. Kopcha, Gary	Richard J. Purcell, Griffith
Seymour W. Shapiro, Gary	
David B. Templin, Lowell	

County and Delegates	Alternates
LA PORTE (2)	
Frank J. McGue, Michigan City	John Luce, Michigan City
E. C. Mueller, LaPorte	J. C. Richter, LaPorte
LAWRENCE (1)	
Joseph Dusard, Bedford	Gerald E. Kasting, Bedford
MADISON (2)	
Robert D. Williams, Anderson	Ted S. Doles, Middletown
P. T. Lamey, Anderson	
MARION (22)	
Joseph L. Haymond, Indianapolis	Richard A. Brickley, Indianapolis
Jack W. Hickman, Indianapolis	W. Stanley Garner, Indianapolis
William A. Karsell, Indianapolis	John D. Graham, Indianapolis
Thomas E. Lunsford, Indianapolis	Kenneth L. Gray, Indianapolis
Louis W. Nie, Indianapolis	M. Richard Harding, Indianapolis
Hunter A. Soper, Indianapolis	Robert F. Nagan, Indianapolis
Charles E. Test, Indianapolis	Henry G. Nester, Indianapolis
F. Robert Brueckmann, Indianapolis	Fred L. Toumey, Indianapolis
Ronald H. Hull, Indianapolis	Robert D. Arnold, Indianapolis
James M. Leffel, Indianapolis	John W. Beeler, Indianapolis
William B. Lybrook, Indianapolis	Robert B. Chevalier, Indianapolis
Donald H. McCartney, Indianapolis	Marvin C. Christie, Indianapolis
Morris E. Thomas, Indianapolis	Frank W. Countryman, Indianapolis
Malcolm L. Wrege, Indianapolis	Robert L. Gregory, Indianapolis
Albert M. Donato, Indianapolis	William M. Walton, Indianapolis
A. Alan Fischer, Indianapolis	Hubert N. Grimes, Indianapolis
James H. Gosman, Indianapolis	George T. Lukemeyer, Indianapolis
Gordon C. Jones, Indianapolis	Robert N. McCallum, Indianapolis
Arvine G. Popplewell, Indianapolis	Edwin S. McClain, Indianapolis
Dwight W. Schuster, Indianapolis	Dennis Nicholas, Indianapolis
Donald E. Stephens, Indianapolis	Michael L. Yacko, Indianapolis
Donald E. Wood, Indianapolis	Robert J. Yingling, Indianapolis
MARSHALL (1)	
MIAMI (1)	
Lloyd L. Hill, Peru	Parker W. Snyder, Peru
MONTGOMERY (1)	
R. R. Eggers, Crawfordsville	J. M. Kirtley, Crawfordsville
MORGAN (1)	
Oliver Wilson, Morgantown	
NEWTON (1)	
NOBLE (1)	
Joseph A. Greenlee, Jr., Avilla	

County and Delegates	Alternates
ORANGE (1)	
P. T. Hodgin, Orleans	Marion Hagan, French Lick
OWEN-MONROE (2)	
J. A. Creek, Bloomington	Harold Manifold, Bloomington
T. T. Skrentny, Spencer	
PARKE-VERMILLION (2)	
Milton Herzberg, Clinton	John Somerville, Clinton
W. D. Britton, Montezuma	Milton Beebe, Rockville
PERRY (1)	
Fred Smith, Jr., Tell City	Gene E. Ress, Tell City
PIKE (1)	
Milton H. Omstead, Petersburg	
PORTER (1)	
John E. Read, Chesterton	
POSEY (1)	
L. John Vogel, Mt. Vernon	John Crist, Mt. Vernon
PULASKI (1)	
William R. Thompson, Winamac	E. L. Hollenberg, Winamac
PUTNAM (1)	
James B. Johnson, Greencastle	James Lett, Greencastle
RANDOLPH (1)	
B. D. Wagoner, Union City	Lowell W. Painter, Winchester
RIPLEY (1)	
Bill Freeland, Batesville	Lloyd W. Hisrich, Batesville
RUSH (1)	
Frank Green, Rushville	Stephen Smith, Knightstown
ST. JOSEPH (5)	
S. E. Bechtold, South Bend	G. M. Haley, South Bend
J. Rosenwasser, Mishawaka	H. A. Schiller, South Bend
W. J. Stogdill, South Bend	D. G. White, South Bend
Louis F. Sandock, South Bend	Paul Macri, Mishawaka
R. W. Holdeman, South Bend	L. D. Borough, South Bend
SCOTT (1)	
Thomas Neathamer, Scottsburg	Marvin McClain, Scottsburg
SHELBY (1)	
W. L. Dalton, Shelbyville	J. A. Davis, Flat Rock
SPENCER (1)	
John C. Glackman, Jr., Rockport	

County and Delegates	Alternates
STARKE (1)	
Guy B. Ingwell, Knox	Clark McClure, Knox
STEUBEN (1)	
John Hartman, Angola	
SULLIVAN (1)	
Joe Dukes, Dugger	Betty Dukes, Dugger
TIPPECANOE (3)	
W. R. Van Den Bosch, Lafayette	Lindley Wagner, Lafayette
Forrest Babb, Stockwell	
Ramon DuBois, Lafayette	
TIPTON (1)	
Albert E. Stouder, Kempton	Meredith Gossard, Tipton
VANDERBURGH (5)	
Ray H. Burnikel, Evansville	Joseph M. Coleman, Evansville
James H. Crawford, Evansville	H. Jerome Rietman, Evansville
George W. Willison, Evansville	Daniel M. Hare, Evansville
John D. Wilson, Evansville	Albert S. Ritz, Evansville
A. Wayne Ratcliffe, Evansville	Weston A. Heinrich, Evansville
VIGO (2)	
William G. Bannon, Terre Haute	James Cristee, Terre Haute
Thomas J. Conway, Terre Haute	Norman Silverman, Terre Haute
WABASH (1)	
WARRICK (1)	
Robert C. Colvin, Newburgh	
WASHINGTON (1)	
E. R. Apple, Salem	C. S. Manship, Hardinsburg
WAYNE-UNION (2)	
Glen Ward Lee, Richmond	Tom Shields, Richmond
Frank Lewis, Liberty	W. B. McWilliams, Liberty
WELLS (1)	
Truman E. Caylor, Bluffton	Charles Caylor, Bluffton
WHITE (1)	
Max L. Fields, Monticello	Nolan A. Hibner, Monticello
WHITLEY (1)	
Thomas Hamilton, Columbia City	

PAST PRESIDENTS

Herman M. Baker, Evansville
Karl R. Ruddell, Indianapolis
M. A. Austin, Evansville
Paul D. Crimm, Evansville
William H. Howard, Hammond
W. U. Kennedy, New Castle
M. C. Topping, Terre Haute
Kenneth L. Olson, South Bend
Earl W. Mericle, Indianapolis
Guy A. Owsley, Hartford City
Maurice E. Glock, Fort Wayne
Donald E. Wood, Indianapolis
Joseph M. Black, Seymour
Kenneth O. Neumann, Lafayette
Eugene S. Rifner, Van Buren

OFFICERS

President—G. O. Larson, LaPorte
President-Elect—Patrick J. V. Corcoran, Evansville
Chairman, Executive Committee—Ralph V. Everly, Indianapolis
Member, Executive Committee—Burton E. Kintner, Elkhart
Treasurer—Lester H. Hoyt, Indianapolis
Chairman of the Council—Lowell H. Steen, Hammond
Assistant Treasurer—Malcolm O. Scamahorn, Pittsboro
Editor—Frank B. Ramsey, Indianapolis
Executive Secretary—James A. Waggener, Indianapolis

COUNCILORS

1st District—Gilbert M. Wilhelmus, Evansville
2nd District—Joe Dukes, Dugger
3rd District—Donald M. Kerr, Bedford
4th District—Robert M. Reid, Columbus
5th District—Wilbert McIntosh, Riley
6th District—Stephen Smith, Knightstown
7th District—Albert M. Donato, Indianapolis
8th District—Donald R. Taylor, Muncie
9th District—Peter R. Petrich, Attica
10th District—Lowell H. Steen, Hammond
11th District—Lowell J. Hillis, Logansport
12th District—William R. Clark, Fort Wayne
13th District—Otis R. Bowen, Bremen

AMA DELEGATES

Guy A. Owsley, Hartford City
Jack E. Shields, Brownstown
Harold C. Ochsner, Indianapolis
Eugene F. Senseny, Fort Wayne
Frank H. Green, Rushville

Fifty-Year Club—1968

BOONE COUNTY
John D. Coons, Lebanon

JACKSON-JENNINGS COUNTY
Harold P. Graessle, Seymour

LAKE COUNTY
Hubert M. English, Gary

MARION COUNTY
J. Carlton Daniel, Laguna Hills, Calif.
William E. Gabe, Orinda, Calif.
J. Kent Leasure, Indianapolis
Robert J. Masters, Indianapolis
James O. Ritchey, Indianapolis
Cecil L. Rudesill, Indianapolis
Edwin Rogers Smith, Indianapolis

MONTGOMERY COUNTY
Byron N. Lingeman, Crawfordsville

PARKE-VERMILLION COUNTY
James S. Noblitt, Rockville

PUTNAM COUNTY
Lester W. Veach, Bainbridge

ST. JOSEPH COUNTY
Carroll C. Hyde, South Bend

WHITLEY COUNTY
Ernest A. Hershey, Churubusco

Reference Committees—1968

REFERENCE COMMITTEE NO. 1:

Warren McClure, Kokomo (Howard), *Chairman*
Seymour W. Shapiro, Gary (Lake)
William G. Bannon, Terre Haute (Vigo)
Gordon S. Fessler, Rising Sun (Dearborn-Ohio)
Wayne H. Endicott, Greenfield (Hancock)

REFERENCE COMMITTEE NO. 2:

Eugene S. Rifner, Van Buren (Grant) *Chairman*
Jack Hickman, Indianapolis (Marion)
Frank J. McGue, Michigan City (LaPorte)
Ross L. Egger, Daleville (Delaware-Blackford)
Jean A. Creek, Bloomington (Owen-Monroe)

REFERENCE COMMITTEE NO. 3:

Malcolm O. Scamahorn, Pittsboro (Hendricks), *Chairman*
Vincent J. Santare, Munster (Lake)
Malcolm L. Wrege, Indianapolis (Marion)
Glen Ward Lee, Richmond (Wayne-Union)
Thomas Neathamer, Scottsburg (Scott)

REFERENCE COMMITTEE NO. 4:

S. E. Bechtold, South Bend (St. Joseph), *Chairman*
Barton T. Smith, Marion (Grant)
Forrest Babb, Stockwell (Tippecanoe)
Walter Able, Columbus (Bartholomew-Brown)
Guy B. Ingwell, Knox (Starke)

REFERENCE COMMITTEE NO. 5:

John D. Wilson, Evansville (Vanderburgh), *Chairman*
George B. Gattman, Elkhart (Elkhart)
Fred Smith, Tell City (Perry)
James H. Gosman, Indianapolis (Marion)
Richard W. Holdeman, South Bend (St. Joseph)

CREDENTIALS:

Dean K. Stinson, Rochester (Fulton), *Chairman*
Philip J. Rosenbloom, Gary (Lake)
Jesse Benz, Marengo (Harrison-Crawford)
Ramon B. DuBois, [illegible] (Tippecanoe)

1967-1968
Officers of the ISMA

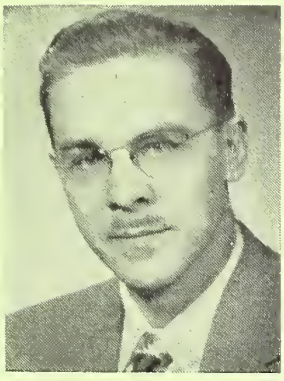
G. O. LARSON, M.D.

President

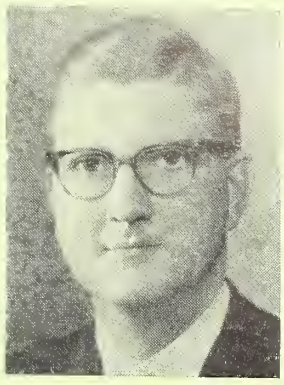
Indiana State Medical Association

1967-68

P. J. V. CORCORAN, M.D.
President-Elect
Evansville



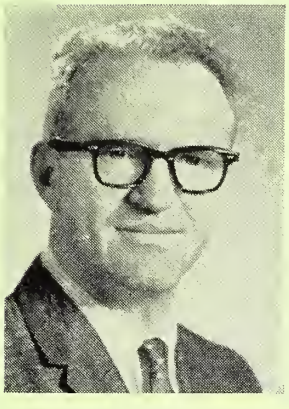
LESTER HOYT, M.D.
Treasurer
Indianapolis



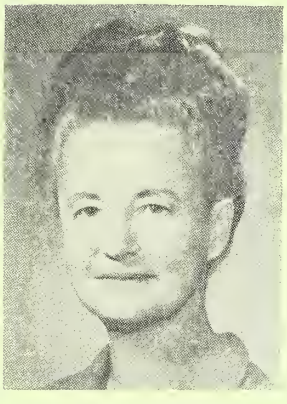
LOWELL H. STEEN, M.D.
Chairman of Council
Hammond

RALPH V. EVERLY, M.D.
Chairman
Executive Committee
Indianapolis

M. O. SCAMAHORN, M.D.
Asst. Treasurer
Pittsboro



BURTON E. KINTNER, M.D.
Executive Committee
Elkhart



BETTY KEPHART
President, Auxiliary
Bluffton

JAMES A. WAGGENER
Executive Secretary
Indianapolis

KENNETH W. BUSH
Administrative Assistant
Indianapolis

ROBERT J. AMICK
Field Secretary
Scottsburg

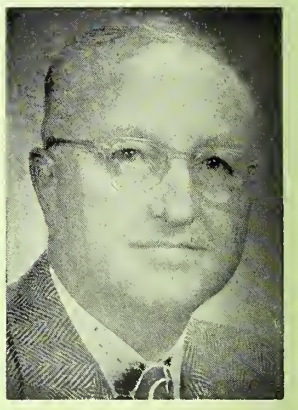
HOWARD CRAWFORD
Field Secretary
Indianapolis

The Journal

FRANK B. RAMSEY, M.D.
Editor
Indianapolis

A. W. CAVINS, M.D.
Associate Editor
Terre Haute

L. G. MONTGOMERY, M.D.
Associate Editor
Muncie

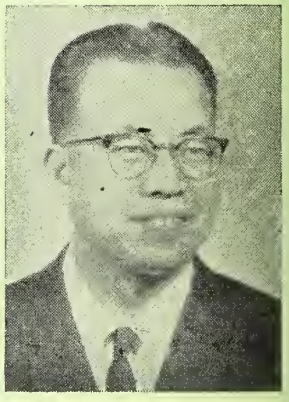


DAVID A. BICKEL, M.D.
Associate Editor
South Bend

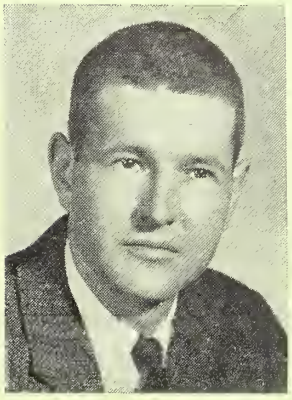
SAMUEL R. MERCER, M.D.
Associate Editor
Fort Wayne

IRVIN W. WILKENS, M.D.
Associate Editor
Indianapolis

ALVIN J. HALEY, M.D.
Editorial Board
Fort Wayne



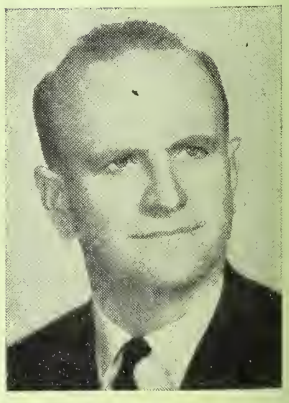
WEI-PING LOH, M.D.
Editorial Board
Gary



JACK W. HICKMAN, M.D.
Editorial Board
Indianapolis

FRANK H. COBLE, M.D.
Editorial Board
Richmond

JENE R. BENNETT, M.D.
Editorial Board
South Bend



W. D. SNIVELY, JR., M.D.
Editorial Board
Evansville

Section Officers

Surgery

CHAIRMEN

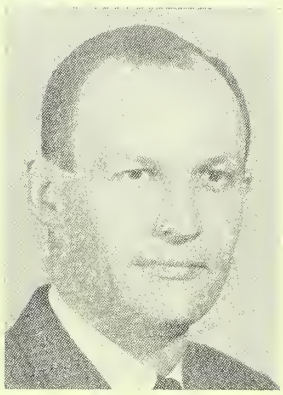
DONALD M. SCHLEGEL, M.D.
Indianapolis

VICE-CHAIRMEN

NO
PICTURE
AVAILABLE

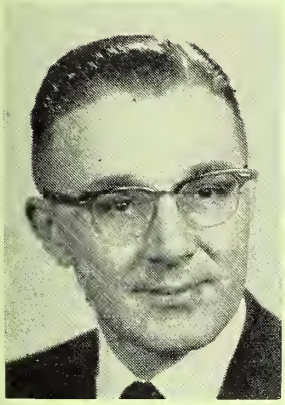
HENRY LARZELERE, M.D.
Marion

SECRETARIES



AUSTIN GARDNER, M.D.
Indianapolis

Internal Medicine



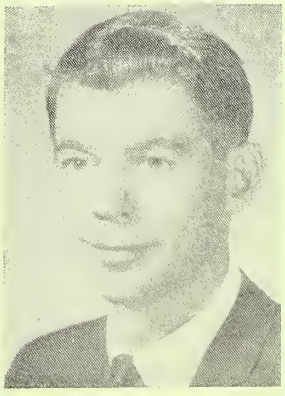
ISAAC E. MICHAEL, M.D.
Indianapolis

LOUIS F. SANDOCK, M.D.
South Bend

ROBERT L. RUDESILL, M.D.
Indianapolis

Ophthalmology and Otolaryngology

DAVID E. BROWN, M.D.
Indianapolis



KENNETH F. ISENOGLE, M.D.
Fort Wayne

GEORGE A. [illegible], M.D.
Indianapolis

Anesthesiology

CHAIRMEN

WILLIAM M. MATTHEWS, M.D.
Indianapolis

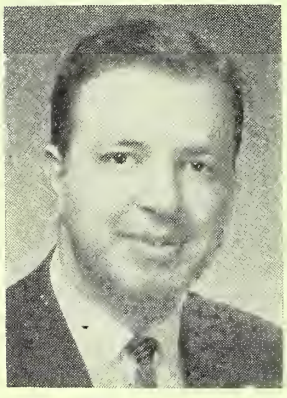
VICE-CHAIRMEN

MERLE E. PICKETT, M.D.
Fort Wayne

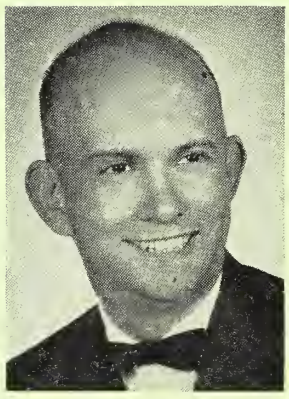
SECRETARIES

JERRY R. MILLER, M.D.
Indianapolis

General Practice



JAY S. REESE, M.D.
Martinsville

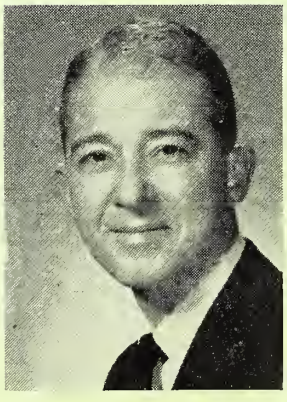


ROBERT MOUSER, M.D.
Indianapolis

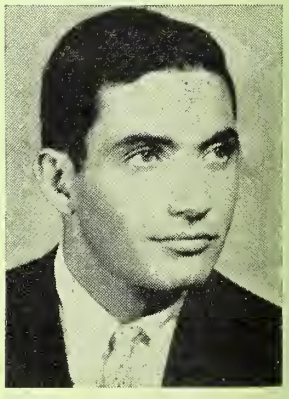
RICHARD JUERGENS, M.D.
Fort Wayne

Obstetrics and Gynecology

ROBERT M. REID, M.D.
Columbus



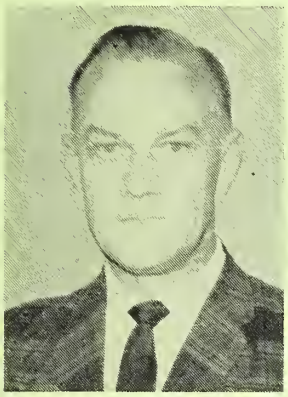
TOM W. WACHOB, M.D.
Kokomo



CHARLES R. ECHT, M.D.
Indianapolis

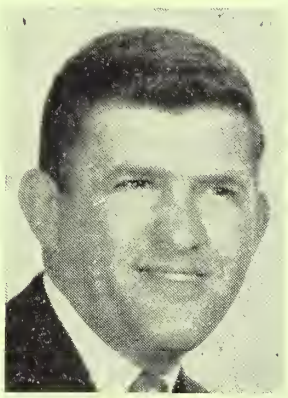
Public Health and Preventive Medicine

CHAIRMEN



DONALD M. KERR, M.D.
Bedford

VICE-CHAIRMEN



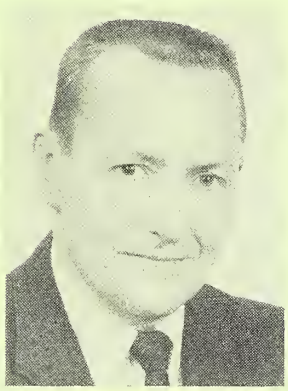
T. NEAL PETRY, M.D.
Delphi

SECRETARIES

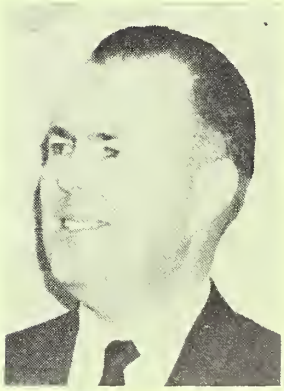
HENRY G. NESTER, M.D.
Indianapolis

Radiology

JOHN A. ROBB, M.D.
Indianapolis

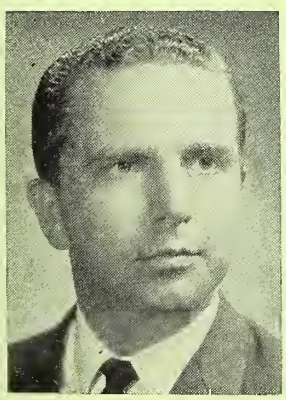


ROBERT E. BECK, M.D.
Evansville



DALE B. PARSHALL, M.D.
Elkhart

Nervous and Mental Diseases



GORDON T. BROWN, M.D.
Indianapolis

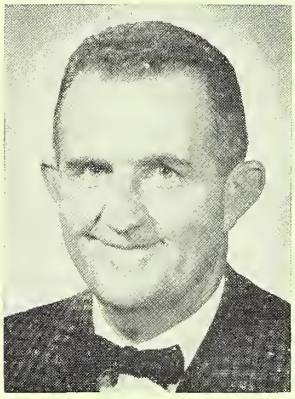
NO
PICTURE
AVAILABLE

JAMES E. BENSON, M.D.
Elkhart

WESLEY A. KISSEL, M.D.
Indianapolis

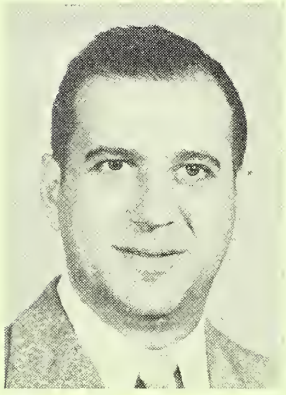
Pathology

CHAIRMEN



ROBERT J. FROST, M.D.
Michigan City

VICE-CHAIRMEN

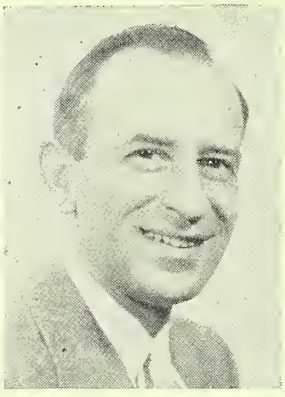


FRANK VELLIOS, M.D.
Indianapolis

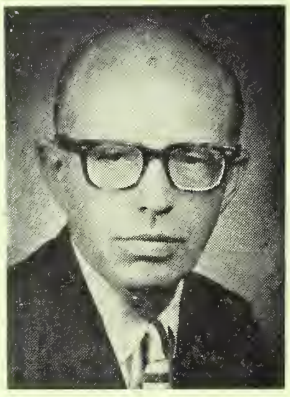
SECRETARIES

ROBERT L. COSTIN, M.D.
Indianapolis

Pediatrics



ROLAND E. MILLER, M.D.
Lafayette



GUSTAF W. ERICKSON, M.D.
South Bend

MORRIS GREEN, M.D.
Indianapolis

Photo Credits

Fabian Bachrach, New York, N.Y.; Clippinger Town House Photography, Fort Wayne; Covert Studio, Evansville; Olive Studio, Evansville; Maurice Roy, La Jolla, Calif.; Walker's House of Photography, Fort Wayne; Watters Studio, Fort Wayne.

Schedule of Events

119th Annual Convention
Indiana State Medical Association
Fort Wayne, Indiana

October 15, 16, 17 and 18, 1968

(All Events on Eastern Standard Time)

(The scientific program of the 119th annual convention of the Indiana State Medical Association is acceptable for 8½ elective hours by the American Academy of General Practice.)

Monday, October 14, 1968

10:00 a.m. — Executive Committee meeting, President's Room, Chamber of Commerce Building.

2:00 p.m. — Council meeting, Auditorium (second floor) Chamber of Commerce Building.

7:30 p.m. — Annual Council Dinner, Penthouse, Three Rivers East.

Tuesday Morning, October 15, 1968

7:30 a.m. — Council breakfast meeting, Canal Room, Chamber of Commerce Building.

8:30 a.m. — Registration begins, Scottish Rite Lobby.

8:30 a.m. — Opening of technical and scientific exhibits, Scottish Rite, Lower Level.

9:00 a.m. — Annual golf tournament, Pine Valley Country Club.

11:00 a.m. to 2:00 p.m. — Time allowed to view technical and scientific exhibits, Scottish Rite, Lower Level.

Tuesday Afternoon, October 15, 1968

2:00 p.m. — Meeting of House of Delegates, Auditorium (second floor) Chamber of Commerce Building.

4:00 to 5:00 p.m. — Time allowed to view technical and scientific exhibits, Scottish Rite, Lower Level.

Tuesday Evening, October 15, 1968

5:30 p.m. — Reception and Delegates' Dinner, Ballroom, Shrine Club, courtesy of Twelfth District Medical Society. Admission by ticket only.

Presentation of awards for athletic events.

8:00 p.m. — Reference Committees meet, Chamber of Commerce Building:

- Reference Committee No. 1—Room No. 1
- Reference Committee No. 2—Room No. 2
- Reference Committee No. 3—Room No. 3
- Reference Committee No. 4—Room No. 4
- Reference Committee No. 5—Room No. 5

Wednesday Morning, October 16, 1968

8:00 a.m. — Council breakfast meeting, Canal Room, Chamber of Commerce Building.

8:30 a.m. — Registration continues, Scottish Rite Lobby.

8:30 a.m. — Technical and scientific exhibits, Scottish Rite, Lower Level.

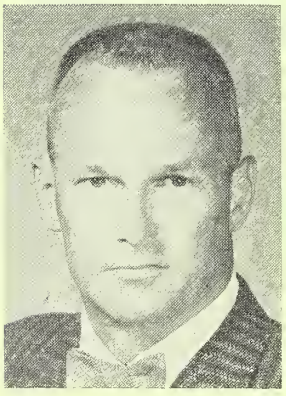
9:00 a.m. — Reference Committee meetings continue. (Check headquarters office, Scottish Rite Lobby).

9:00 a.m. — Closed circuit TV, Auditorium, Exhibit Floor Level, Scottish Rite.

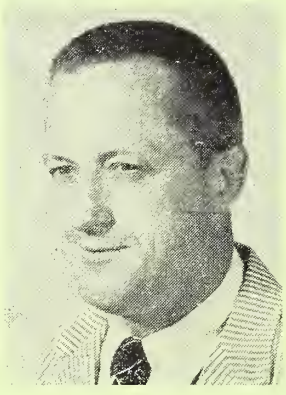
9:30 a.m. — Orientation meeting for new members, Candidates Room, (second floor), Scottish Rite.

ROBERT G. IRISH, LL.D.
Fort Wayne
Partner, Hood, Gust, Irish & Lundy, patent lawyers, Fort Wayne, 1957 to present; Formerly patent lawyer for the General Electric Company; LL.D. degree from the George Washington University Law School, 1946.

JAMES J. FEFFER, M.D.
Washington, D.C.
Associate Dean for Clinical Affairs, George Washington University Medical Center, Washington, D.C.; Clinical Professor and Chairman, Section of Pulmonary Disease, George Washington University; M.D. degree from the I.U. School of Medicine, 1938.



JACK SCHREIBER, M.D.
Canfield, Ohio
General practitioner; Member of the AMA's Speaker's Bureau since 1961; Recipient of the George Washington Medal Award of the Freedom Foundation of Valley Forge for 1966; M.D. degree from University of Cincinnati College of Medicine, 1954.



DAVID E. COPHER, M.D.
Indianapolis
Assistant Professor, Department of Obstetrics and Gynecology, I.U. School of Medicine; Recipient of research grant in neonatal intensive care at the Department of Pediatrics, Karolinski Institute, Stockholm; M.D. degree from the I.U. School of Medicine, 1962.

SECTION MEETINGS

10:30 a.m. SECTION ON SURGERY, Indiana Chapter, American College of Surgeons, and Indiana Section, International College of Surgeons joint luncheon meeting, Auditorium, Chamber of Commerce Building

"Patented Medicine,"

ROBERT G. IRISH, LL.D., Fort Wayne

Election of Section officers for 1969.

10:30 a.m. SECTION ON INTERNAL MEDICINE and Indiana Society of Internal Medicine joint luncheon meeting, St. Joseph's Hospital.

"The Paradox of the Doctor Shortage,"

JAMES J. FEFFER, M.D., Washington, D.C.

Election of Section officers for 1969.

10:30 a.m. SECTION ON ANESTHESIOLOGY Auditorium, Chamber of Commerce Building. (Not a luncheon meeting).

Election of Section officers for 1969.

10:30 a.m. SECTION ON GENERAL PRACTICE luncheon meeting, Ballroom, Shrine Club.

"Mechanics of Confusion,"

JACK SCHREIBER, M.D., Canfield, Ohio

Election of Section officers for 1969.

10:30 a.m. SECTION ON OBSTETRICS AND GYNECOLOGY luncheon meeting, Room No. 5, Chamber of Commerce Building.

"Present Aspects of Fetal Intensive Care,"

DAVID E. COPHER, M.D., Indianapolis

Election of Section officers for 1969.

Wednesday Morning, October 16, 1968

10:30 a.m. SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE luncheon meeting, Room No. 4, Chamber of Commerce Building.

"Problems and Solutions in Epidemiology,"

HENRY G. NESTER, M.D., Indianapolis

Election of Section officers for 1969.

HENRY G. NESTER, M.D.
Indianapolis
Director of Public Health of Indianapolis and Marion County, 1952-1968; Consultant in public health, St. Vincent's Hospital, Indianapolis; M.D. degree from the Indiana University School of Medicine, 1949.

10:30 a.m. SECTION ON NERVOUS AND MENTAL DISEASES and Indiana Neuropsychiatric Association joint luncheon meeting, Hall's Gas House.

"Drugs of Abuse,"

DANIEL X. FREEDMAN, M.D., Chicago

Election of Section officers for 1969.

DANIEL X. FREEDMAN, M.D.
Chicago, Ill.
Professor and Chairman, Department of Psychiatry, University of Chicago; Specialist in psychiatry, psychoanalysis and psychopharmacology; M.D. degree from Yale University School of Medicine, 1951.

10:30 a.m. SECTION ON DIRECTORS OF MEDICAL EDUCATION luncheon meeting, Big Wheel Restaurant on the Landing.

"Recent Council on Medical Education Developments,"

FRANCIS L. LAND, M.D., Washington, D. C.

Election of Section officers for 1969.

10:30 a.m. SECTION ON PEDIATRICS luncheon meeting, Room No. 1, Chamber of Commerce Building.

"Childhood Nephrosis; Some Recent Advances,"

CARL W. TRYGSTAD, M.D., Indianapolis

Election of Section officers for 1969.

FRANCIS L. LAND, M.D.
Washington, D.C.
Commissioner of the Department of Health, Education and Welfare's Medical Services Administration; Former president of the Indiana Academy of General Practice; M.D. degree from the I.U. School of Medicine, 1950.

11:00 a.m. Editorial Board meeting, President's Room, Chamber of Commerce Building. (Luncheon at noon.)

11:00 a.m. to 12 noon Time allowed to view technical and scientific exhibits, Scottish Rite, Lower Level.

CARL W. TRYGSTAD, M.D.
Indianapolis
Assistant Professor of Pediatrics, Indiana University School of Medicine; Specialist in pediatrics and nephrology; M.D. degree from the University of Florida School of Medicine, 1961.

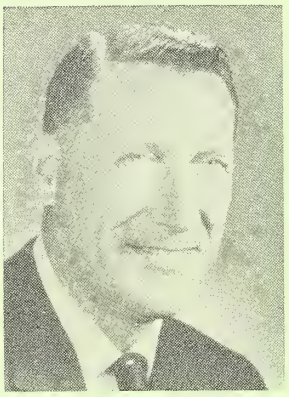
Wednesday Noon, October 16, 1968

12 noon SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY luncheon meeting, Room No. 6, Chamber of Commerce Building.

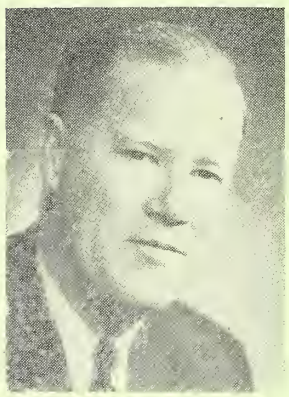
Election of Section officers for 1969.

SPEAKERS

WALTER M. WHITEHOUSE, M.D.
Professor and Chairman, Department of Radiology, University of Michigan Medical School, Ann Arbor; M.D. degree from the University of Michigan, 1941.



FREDERIC W. BROWN, M.D.
Fort Wayne
Chief of Orthopaedic Service, Lutheran Hospital; Consultant to the Veterans Administration Hospital and the Fort Wayne State School, Fort Wayne; M.D. degree from the University of Loyola, Chicago, Ill., 1940.



J. CUTHBERT OWENS, M.D.
Denver, Colo.
Professor, Department of Surgery, University of Colorado Medical Center, Denver; Specialist in general surgery, cardiovascular and peripheral vascular surgery; M.D. degree from Marquette University School of Medicine, 1941.

Wednesday Noon, October 16, 1968

12 noon — SECTION ON RADIOLOGY and Indiana Roentgen Society joint luncheon meeting, Auditorium, Chamber of Commerce Building.

"Radiological Aspects of Bronchial Neoplasms,"

WALTER M. WHITEHOUSE, M.D., Ann Arbor, Mich.

Election of Section officers for 1969.

12 noon — SECTION ON PATHOLOGY luncheon meeting, Room No. 2, Chamber of Commerce Building.

Election of Section officers for 1969.

12 noon — Luncheon meeting of Past Presidents of the Indiana State Medical Association, Room No. 3, Chamber of Commerce Building.

Wednesday Afternoon, October 16, 1968

1:00 p.m. — Flying Physicians Association, Indiana Chapter, meeting, Auditorium, Chamber of Commerce Building. (Not a luncheon meeting.)

1:00 to 1:30 p.m. — Time allowed to view technical and scientific exhibits, Scottish Rite, Lower Level.

GENERAL MEETING

(Auditorium, Exhibit Floor Level, Scottish Rite)

Call to order by G. O. Larson, M.D., LaPorte, President, Indiana State Medical Association.

Symposium on "Surgical Aspects of Trauma,"

FREDERIC W. BROWN, M.D., Fort Wayne, chairman and moderator.

1:30 p.m. — *"The Evaluation and Upgrading of Emergency Care,"*

J. CUTHBERT OWENS, M.D., Denver, Colo.

Wednesday Afternoon, October 16, 1968

2:00 p.m. *"The Evaluation and Care of Patients with Shock and Thoracic Injury,"*

ERNEST M. BERKAS, M.D., Dearborn, Mich.

ERNEST M. BERKAS, M.D.
Dearborn, Mich.
Associate Professor of Surgery, Wayne State University, Detroit; Specialist in general and thoracic surgery; M.D. degree from the University of Minnesota School of Medicine, 1952.

2:30 p.m. *"The Management of Patients with Burns: Fluid and Electrolyte Therapy and Use of New Surface Agents,"*

BRUCE E. ZAWACKI, Captain, MC, U. S. Army, Fort Sam Houston, Texas

3:00 p.m. *"Evaluation and Evacuation of War Casualties—Application in Civilian Disasters,"*

THEODORE H. WILSON, Jr., Captain, MC, USN, Bethesda, Md.

BRUCE E. ZAWACKI,
CAPTAIN, M.C.
Fort Sam Houston, Texas
Chief, Trauma Study Branch, U.S. Army Surgical Research Unit, Fort Sam Houston, Texas; Specialist in burns and burn research; M.D. degree from Harvard Medical School, 1961.

3:30 p.m. Intermission

3:30 to 4:00 p.m. Time allowed to view technical and scientific exhibits, Scottish Rite, Lower Level.

4:00 to 4:45 p.m. Panel discussion.

Wednesday Evening, October 16, 1968

5:30 p.m. Reception Fifty-Year Club, Cutter's Chalet.

6:00 p.m. President's Reception, Cutter's Chalet.

7:00 p.m. President's Dinner, Cutter's Chalet

Presiding Officer: G. O. LARSON, M.D., President, Indiana State Medical Association.

Invocation: Victor P. Frohne, St. Paul's United Church of Christ, LaPorte.

Recognition of Fifty-Year Club members.

Presentation of Mental Health Award.

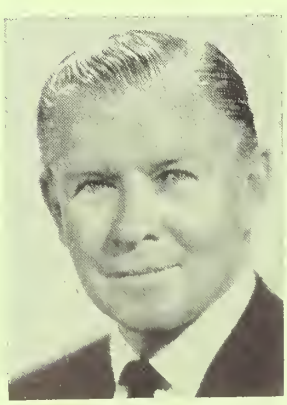
Presentation of Public Relations Awards.

Speaker:

HON. SEN. GEORGE L. MURPHY (R.-Calif.)

Presentation of plaque to G. O. LARSON, M.D., LaPorte, president, 1968 by PATRICK J. V. CORCORAN, M.D., president, 1969.

THEODORE H. WILSON, Jr.,
CAPTAIN, M.C.
Bethesda, Md.
Chief of Surgery, Naval Hospital, National Naval Medical Center, Bethesda, Md.; Specialist in general surgery; M.D. degree from Harvard Medical School, 1946.



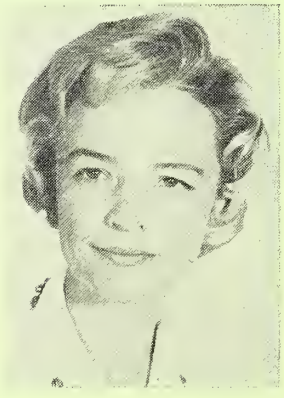
SEN. GEORGE L. MURPHY
Washington, D.C.
United States Senator from California; Member of the Senate Committee on Labor and Public Welfare and the Committee on Public Works; Member of the Senate Special Committee on the Arts and the Special Committee on Aging; Chairman of the National Republican Senatorial Committee.

SPEAKERS

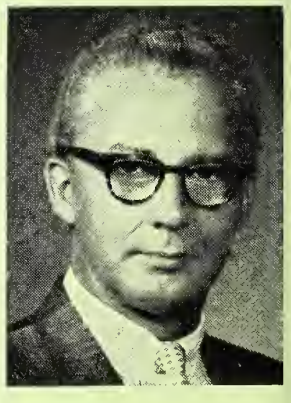
JOHN B. HICKAM, M.D.
Indianapolis
Professor of Medicine and Chairman, Department of Medicine, I.U. School of Medicine; Former Professor of Medicine, Duke University School of Medicine; M.D. degree from Harvard University School of Medicine, 1940.

EDWARD R. ANNIS, M.D.
Miami, Fla.
Past-president of the American Medical Association; Former president of the World Medical Association; Specialist in general surgery and gynecology; M.D. degree from Marquette University School of Medicine, 1938.

DWIGHT L. WILBUR, M.D.
San Francisco, Calif.
President, American Medical Association; Clinical Professor of Medicine, Stanford School of Medicine; M.D. degree from the University of Pennsylvania, 1926.



SUZANNE B. KNOEBEL, M.D.
Indianapolis
Assistant Professor of Medicine, Indiana University School of Medicine; Specialist in cardiology; Senior Research Associate, Krannert Institute of Cardiology; M.D. degree from the I.U. School of Medicine, 1960.



JOHN F. PHILLIPS, M.D.
Bluffton
Assistant Professor of Medicine, I.U. School of Medicine; Cardiologist, Caylor-Nickel Clinic, Bluffton; M.D. degree from the Indiana University School of Medicine, 1944.

Thursday Morning, October 17, 1968

8:00 a.m. Council breakfast meeting, Canal Room, Chamber of Commerce Building.

8:30 a.m. Registration continues, Scottish Rite Lobby.

8:30 a.m. Technical and scientific exhibits, Scottish Rite, Lower Level.

GENERAL MEETING

(Auditorium, Exhibit Floor Level or Theatre, Scottish Rite)

G. O. Larson, M.D., LaPorte, president, Indiana State Medical Association, presiding.

Medicine in the 70's

9:00 to 11:00 a.m.

"Medical Education Prepares for the Future,"

JOHN B. HICKAM, M.D., Indianapolis
"Society's Developing Needs and Government's Response to Them,"

IRVING J. LEWIS, Washington, D.C.
"Society's Developing Needs—Private Medicine's Response to Them,"

EDWARD R. ANNIS, M.D., Miami, Florida

"Organized Labor as a Representative of the Consumer,"

DALLAS SELLS, Indianapolis
"American Medicine Leads the Way,"

DWIGHT L. WILBUR, M.D., San Francisco, Calif.

11:00 a.m. to 12 noon Time allowed to view technical and scientific exhibits, Scottish Rite, Lower Level.

Thursday Noon, October 17, 1968

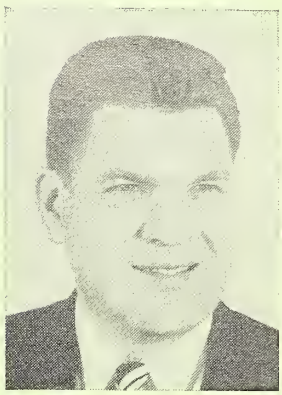
12 noon — Luncheon for Women Physicians of Indiana, Fort Wayne Country Club, 5221 Covington Rd.

Phi Rho Sigma luncheon, Auditorium, Chamber of Commerce Building.

Phi Chi luncheon, Room No. 3, Chamber of Commerce Building.

Phi Beta Pi luncheon, President's Room, Chamber of Commerce Building.

Nu Sigma Nu luncheon, Auditorium, Chamber of Commerce Building.



WILLIAM C. ELLIOTT, M.D.
Indianapolis
Assistant Professor of Medicine, Indiana University School of Medicine; Specialist in cardiology and coronary arteriographic studies; M.D. degree from the University of North Carolina School of Medicine, 1958.

Thursday Afternoon, October 17, 1968

GENERAL MEETING

(Auditorium, Exhibit Floor Level, Scottish Rite)

G. O. Larson, M.D., LaPorte, president, Indiana State Medical Association, presiding.

Panel on "Diagnosis and Treatment of Coronary Diseases,"

Chairmen: SUZANNE B. KNOEBEL, M.D., Indianapolis

JOHN F. PHILLIPS, M.D., Bluffton

HERMAN K. HELLERSTEIN, M.D.
Cleveland, Ohio
Associate Professor of Medicine, Western Reserve University; Chief, Cardiology Outpatient Department, University Hospitals of Cleveland; M.D. degree from Western Reserve University School of Medicine, 1941.

1:30 p.m. — *"Coronary Cineangiography in the Diagnosis and Management of Coronary Artery Disease,"* WILLIAM C. ELLIOTT, M.D., Indianapolis

2:00 p.m. — *"The Electrocardiogram in the Diagnosis of Coronary Artery Disease,"* HERMAN K. HELLERSTEIN, M.D., Cleveland, Ohio

E. GREY DIMOND, M.D.
LaJolla, Calif.
Professor of Medicine-in-Residence, University of California at San Diego; Director, Institute for Cardiopulmonary Diseases, Scripps Clinic and Research Foundation, LaJolla; M.D. degree from the I.U. School of Medicine, 1944.

2:30 p.m. — *"Role of Coronary Care Unit in the Management of Myocardial Infarction,"* E. GREY DIMOND, M.D., LaJolla, California

3:00 p.m. — *"Role of Surgery in the Management of Coronary Artery Disease,"* WILLIAM H. SEWELL, M.D., Sayre, Pa.

WILLIAM H. SEWELL, M.D.
Sayre, Pa.
Specialist in cardiac surgery; Interests directed primarily toward the physiological, pharmacological, medical, radiological and surgical aspects of coronary disease; M.D. degree from Yale University School of Medicine, 1950.

3:30 p.m. — Intermission.

4:00 to 5:00 p.m. — PANEL—Drs. Dimond, Elliott, Hellerstein, Sewell and Knoebel, moderator.

Thursday Evening, October 17, 1968

8:00 p.m. Music Festival, The Lantern.

8:00 to 9:00 p.m. Concordia Singers. History of Jazz.

9:30 p.m. to 12 midnight Combo and dancing until 12 midnight. Cash bar opens at 9:30 p.m.

Friday Morning, October 18, 1968

9:00 a.m. Final meeting of House of Delegates, Parlors, Women's Club.

Election of officers.

Meetings of Council and Executive Committee, immediately following adjournment of House of Delegates.

Adjournment.

Auxiliary Program

Advance reservations to:
Mrs. Galen C. Huffman, Bluffton, or
Mrs. William A. Kleifgen, Fort Wayne,
co-chairmen

Tuesday, October 15, 1968

9:00 a.m. to 5:00 p.m. Registration, Scottish Rite Lobby.

Wednesday, October 16, 1968

9:00 a.m. Registration continues, Scottish Rite Lobby.

9:00 a.m. Executive Committee Meeting, Wolf and Dessaur's Tea Room.

10:00 a.m. General Board Meeting, Wolf and Dessaur's Tea Room.

12:00 noon President's Luncheon, Wolf and Dessaur's Tea Room.
Casual modeling.
Door prizes.

Wednesday Evening, October 16, 1968

6:00 p.m. President's Reception, Cutter's Chalet.

7:00 p.m. President's Dinner, Cutter's Chalet.

Thursday, October 17, 1968

12:00 noon Bus tour of historic sites and luncheon for physician's wives.

Convention Arrangements Committees—1968

GENERAL CONVENTION ARRANGEMENTS: Charles H. Aust, Fort Wayne, chairman; Durward W. Paris, Kokomo, vice-chairman; William M. Kendrick, Mooresville, secretary; Richard B. Hovda, Evansville; William F. Howard, Bloomington; Irvin Sonne, New Albany; Merritt O. Alcorn, Madison; John E. Freed, Jr., Terre Haute; John Mader, Richmond; Francis E. Stout, Muncie; Boyd A. Burkhardt, Tipton; John L. Ferry, Whiting; James D. Finfrock, Elkhart; Kenneth Kohlstaedt, Indianapolis; Charles Fisch, Indianapolis.

ENTERTAINMENT: William M. Kendrick, Mooresville, chairman; William F. Howard, Bloomington; Richard W. Emme, Fort Wayne.

SCIENTIFIC EXHIBITS: Kenneth G. Kohlstaedt, Indianapolis.

WOMEN PHYSICIANS: Margaret J. Ball, Fort Wayne, chairman; Betty Dukes, Dugger.

WOMEN'S ENTERTAINMENT: Mrs. William A. Kleifgen, Fort Wayne, and Mrs. Galen C. Huffman, Bluffton, co-chairmen.

ART AND HOBBY SHOW: Charles P. Schneider, Evansville, and Ray H. Burnikel, Evansville, co-chairmen.

MEN'S GOLF TOURNAMENT: Boyd A. Burkhardt, Tipton; Kenneth F. Isenogle, Fort Wayne.

Reports of Officers

Executive Secretary

The popular advertising slogan of "something new has been added" might be appropriately applied to the executive offices of the association because of the ever increasing volume of work due, principally, to the many government programs and many commission and committee activities which have increased considerably during the past year.

Few of the members realize the extent of the association's activities. Few are aware of the demands made upon the executive offices. The reasons for this situation are readily explained.

First of all, the association has 13 commissions, most of whom also have subcommittees; four standing committees and the Council, with nine councilor committees, and most or all of these are active.

In the second place, the membership is growing year by year and more members are turning to the headquarters office for assistance. The secretary and his staff take great satisfaction in serving the membership. It is a pleasure to receive inquiries, to have physicians come to the office to ask for favors, etc.

Some of the various projects of the association during the past year have been participation in and contribution to organizations allied with, or related to medicine. For example, the new programs which have come into being in recent months are the Comprehensive Health Planning—O.E.O.—H.U.D.—Regional Medical Programs—(Heart, Cancer, Stroke)—welfare and other third party programs.

In addition, the use of the headquarters building for meetings is constantly increasing.

The latest addition to medically oriented groups to use the building will be the Indiana chapter of the Student American Medical Association and the association will assist this group in programming their meetings.

Perhaps one of the major increases in activities has been the OCHAMPUS Program. Four additional staff members have been added to take care of the increased load. Expansion of the program, training of personnel, changes in regulations and increased computer time has caused some serious delays in handling the increased work load; however, as of August 1, we are happy to report that every claim received in this department has been checked and sent on to the computer for check writing or returned to the physician for additional information within three days time. You might also be interested to know that as of August 1, Indiana physicians and other suppliers have received $933,480.25 through this program—that is just a little short of one million dollars having been paid for the care of these people within the state of Indiana. The expenses connected with the operation for this department are paid by the Department of Defense.

The field staff have also had a busy year, having traveled over forty thousand miles, visiting physicians, component county medical societies, and maintaining their contact with members of the State Legislature and the Congress. The staff will be in Indianapolis full-time during the session of the 1969 Legislature. It is hoped that as funds become available and staff personnel are found, that the field service will be expanded to more adequately serve the group needs of our county and district societies.

While membership continues to grow—on the basis of projected requirements of Indiana, we are far short. During the past 20 years, we have had a net gain of 732 members (1948—3,689; 1967—4,421). If we meet the projected need by 1970, we will need to show a net growth of 1,579 within the next two years (based on the I.U. projection of needs for physicians by 1970). It is hoped the increased activities of developing internships through the Indiana Plan will be an effective force in increasing the medical manpower in our state.

The assets of this association continue to grow and in checking the past 20 years, we find that the total assets as of December 31, 1948, according to the audit, shows a total of $80,646.22—the audit for the period ending September 30, 1967, reflects total assets of $823,871.

No little time of the executive staff has been devoted to planning and handling details of the 119th annual convention, which promises to be an outstanding event.

What does all this mean? It means that your association is alive—is progressing—is making its influence felt.

Your secretary wishes to express his appreciation for the cooperation shown by the secretaries of the county medical societies who are called upon continually for information. We hesitate many times to send them so many notices, bulletins and letters because they are so busy, but there seems to be no other way.

On July 1 of this year, Miss Lucille Kribs, who has been the Assistant of the Association for approximately 40 years, voluntarily retired to enjoy some traveling she has long wanted to do. Miss Elsie Reid, a veteran employee has been advanced to Miss Krib's desk and new staff has been added to replace the void created by the promotion of Miss Reid. Miss Reid, Mr. Amick, Mr. Grindstaff, Mr. Bush and Mrs. Stahl, Assistant Editor of *The Journal*, and all the other staff employees in the headquarters office, join with the secretary in thanking the association officers and members for their many kind considerations.

Physicians, like people in all walks of life, are concerned about the future—what it holds for the medical profession is uncertain in a world as unstable as ours.

Members of the association can be certain, however, that whatever the future holds, the executive secretary and his staff will put forth every effort in their behalf.

JAMES A. WAGGENER,
Executive Secretary

The Treasurer

Inasmuch as the fiscal year of the association ends on September 30th and the audit is not available, it is impossible to present the audit for the year at the time of the meeting of the House of Delegates. Therefore the audit for the year ending September 30, 1967, is incorporated in my report for this year. In addition I will give you a cash report as of the 31st of July, 1968, which reflects the position of the association at the end of ten months of the current fiscal year:

SUMMARY OF ALL FUNDS

	Cash	*Investments*	*Total*
General Fund	$37,890.06	$259,297.21	$297,187.27
Journal Fund	309.84	—	309.84
Medical Defense Fund	3,153.79	25,000.00	28,153.79
Building Fund	3,458.87	—	3,458.87
Building Fund—Auxiliary Donation—		3,863.18	3,863.18
Student Loan Fund (old)	430.00	13,781.51	14,211.51
Dues Account	7,828.87	—	7,828.87
Kitchen Account Fund	—	4,436.45	4,436.45
Total all Funds—	$53,071.43	$306,378.35	$359,449.78

Comparing this with the start of one year ago on July 31, 1967, we had total

cash on hand in all funds of $22,514.69 against the $53,071.43 as of July 31, 1968, which gives us an increase of $30,556.74. Our investment account as of July 31, 1967, amounted to $299,080.07 as against $306,378.35 at the end of July 31, 1968, for an increase of $7,298.28. Total cash and investments of all funds as of July 31, 1967, amounted to $321,594.76. The comparable figure as of July 31, 1968, is $359,449.78 for an increase of $37,855.02.

The Executive Committee and the Council have reviewed the investment portfolio of the association at each of its meetings and the treasurer has followed the advice of these bodies by investing a cash in short term bills or in savings a counts in order to accumulate as much i terest as possible where funds were n required for current purposes. Indicatio at the present time show we will l within our budget for the fiscal year.

LESTER H. HOYT, M.D., *Treasur*

INDIANA STATE MEDICAL ASSOCIATION

Financial statements for the year
ended September 30, 1967
with
supplementary data

The Council,
Indiana State Medical Association,
Indianapolis, Indiana.

We have examined the statement of financial condition of Indiana State Medical Association at September 30, 1967, and the related statements of income and expense of the general fund and changes in fund balances for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying statements present fairly the financial position of Indiana State Medical Association at September 30, 1967, and the results of its general fund operations and changes in fund balances for the year then ended in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

The accompanying supplementary data has been subjected to the auditing procedures applied in the examination of the financial statements mentioned above. The supplementary data is not considered necessary for a fair presentation of the financial statements but is submitted as additional analytical information. In our opinion, the supplementary data is fairly stated in all material respects in relation to the financial statements taken as a whole.

Geo. S. Olive & Co.
Certified Public Accountants

Indianapolis, Indiana
October 23, 1967

Exhibit

INDIANA STATE MEDICAL ASSOCIATION

Statement of General Fund Income and Expense,
Year Ended September 30, 1967

	Actual	Budget
Income:		
Dues	$312,701.25	$310,38
Less: Dues allocated as follows:		
Building fund	38,790.00	38,60
American Medical Education Fund	19,395.00	19,30
The Journal	31,944.00	31,68
Medical Defense fund	4,848.75	4,82
	94,977.75	94,40
Dues available for general fund operations	217,723.50	215,97
Other income:		
Interest income on investments	9,070.97	5,00
Received from American Medical Association	2,572.63	1,50
Miscellaneous	1,480.20	...
	230,847.30	222,47
Expense:		
Committees and commissions—schedule A-1	22,997.24	22,15
Officers and Council—schedule A-1	31,691.63	29,70
Headquarters office—schedule A-2	153,045.95	147,00
Annual meeting expense—schedule A-3	(195.46)	2,00
Dues, subscriptions and donations	3,384.07	3,50
Employees' retirement expense	9,875.88	8,30
Bookkeeping equipment	.....	52
	220,799.31	213,17
	10,047.99	9,30
The Journal—excess of income over expenses—schedule A-4	4,306.24	4,43
Net Income	$ 14,354.23	$ 13,73
Allocated As Follows:		
General fund—exhibit C	$ 20,640.58	
Building fund—exhibit C	(6,286.35)	
	$ 14,354.23	

The accompanying notes are an integral part of this statement

INDIANA STATE MEDICAL ASSOCIATION

Statement of Financial Condition at September 30, 1967

ASSETS

General Fund:			
Cash on deposit and on hand			$ 38,403.33
Cash in savings account			25,414.21
Certificate of deposit			50,000.00
U. S. Government obligations:			
U. S. Treasury bills	$ 94,697.79		
U. S. Treasury bonds	50,068.48		
		144,766.27	
Cash and securities in escrow account			1,000.00
Reimbursement due from U. S. Government for processing Medicare claims			2,121.05
Prepaid expenses			3,710.83
Office furniture and fixtures—at cost	74,987.04		
Less: Accumulated depreciation	41,206.91		
		33,780.13	
Due from The Journal		3,031.20	
			$302,227.02

Building Fund:			
Cash on deposit		3,192.50	
Cash in savings account		3,863.18	
Due from general fund		30.00	
Prepaid expense		66.66	
Meridian Street property:			
Land		69,187.60	
Office building	$299,354.38		
Less: Accumulated depreciation	32,646.98		
		266,707.40	
		335,895.00	
Rental properties—at cost (net of $2,866 accumulated depreciation)		90,292.20	
			433,339.54
Student Loan Fund:			
Cash in savings account		11,293.72	
Certificates of deposit—note 4		20,810.00	
Notes receivable from students		7,896.28	
			40,000.00
The Journal:			
Cash on deposit and on hand		229.23	
Accounts receivable		7,641.70	
State Medical Journal Advertising Bureau common stock		200.00	
Dues allocation receivable from general fund (1st quarter 1967-1968)		7,986.00	
			16,056.93
Medical Defense Fund:			
Cash on deposit		1,045.08	
Accrued interest receivable		243.75	
U. S. Treasury bonds		30,164.93	
Due from general fund		793.75	
			32,247.51
Medicare Program Fund:			
Cash on deposit		19,479.63	
Reimbursement due from U. S. Government for advance payments made to doctors		55,680.37	
			75,160.00
			$899,031.00

The accompanying notes are an integral part of this statement.

Exhibit B

LIABILITIES AND FUND BALANCES

General Fund:			
Accounts payable		$ 1,563.08	
Accrued payroll and property taxes		3,792.87	
Allocation of dues payable to American Medical Education and Research Fund		19,335.00	
Advances from American Medical Association		10,319.19	
Deposits on tape recordings		415.50	
Unearned portion of 1966 dues		73,173.75	
Exhibitors' deposits for 1966 annual meeting		15,600.00	
Due to other funds:			
Building fund	$ 30.00		
Medical Defense fund	793.75		
		823.75	
Fund balance—exhibit C.		177,203.88	
			$302,227.02
Building Fund:			
Notes payable, bank—note 3		14,250.00	
Loans from members (non-interest bearing)		23,325.00	
Accrued property taxes		894.57	
Guarantee and damage deposits		425.00	
Fund balance—exhibit C		394,444.97	
			433,339.54
Student Loan Fund:			
Fund balance—exhibit C:			
Principal balance appropriated from general fund—note 4		40,000.00	
			40,000.00
The Journal:			
Accounts payable		5,020.17	
Accrued payroll taxes		19.56	
Due to general fund		11,017.20	
Fund balance—exhibit C		.....	
			16,056.93
Medical Defense Fund:			
Fund balance—exhibit C		32,247.51	
			32,247.51
Medicare Program Fund:			
Claims payable to doctors		160.00	
Fund balance (cash advanced by U. S. Government)—exhibit C		75,000.00	
			75,160.00
			$899,031.00

INDIANA STATE MEDICAL ASSOCIATION

Statement of Changes in Fund Balances,
Year Ended September 30, 1967

	General Fund	Building Fund	Student Loan Fund	The Journal	Medical Defense Fund	Medicare Fund
Balances, October 1, 1966	$151,749.96	$362,848.26	$ 44,813.34	$.....	$36,138.24	$70,000.00
Additions:						
Net income year ended September 30, 1967—exhibit A	20,640.58	(6,286.35)				
Dues allocated to restricted funds		38,790.00			4,848.75	
Other income credited directly to restricted funds		85.47			1,035.28	
Contribution received		25.00				
Additional funds advanced by U. S. Government						5,000.00
	20,640.58	32,614.12			5,884.03	5,000.00
Deductions:						
Expenses charged directly to restricted funds:						
Building fund:						
Rental property expense (net of rental income of $5,100).		1,017.41				
Medical Defense fund:						
Legal fees					4,200.00	
Malpractice defense fees					5,574.76	
		1,017.41			9,774.76	
Interfund Transfer:						
Transfer of accumulated contributions and unexpended income from the Student Loan fund to the general fund—note 4	4,813.34		(4,813.34)			
	4,813.34		(4,813.34)			
Balances, September 30, 1967—exhibit B	$177,203.88	$394,444.97	$ 40,000.00	$.....	$32,247.51	$75.000.00

The accompanying notes are an integral part of this statement.

INDIANA STATE MEDICAL ASSOCIATION

Notes to Financial Statements at September 30, 1967

NOTE 1—GENERAL PURPOSE AND NATURE:

The association was organized as the Indiana State Medical Society in 1849. The Articles of Incorporation were amended in 1926 to change the name to the Indiana State Medical Association.

The purposes for which the association was formed were to extend medical knowledge; advance medical science; elevate standards of medical education; enlighten the public in regard to problems of medical care, public health, cure of disease; thereby prolonging and adding comforts to life.

The association is exempt from the payment of federal income tax under the provisions of section 501 of the Internal Revenue Code as an organization formed and operated to promote the objectives outlined above.

NOTE 2—METHOD OF ACCOUNTING AND BASIS OF ASSETS:

The association maintains its books and records on the accrual basis. Investments in securities, rental properties and various other assets reflected in the statement of financial condition are carried at cost if purchased or at market value at date of receipt if acquired by gift. Unless stated otherwise, the market value of investments approximates cost.

Fixed assets are carried at cost and are depreciated on the straightline basis with such depreciation charged as a general fund operating expense.

NOTE 3—NOTES PAYABLE TO BANK:

At September 30, 1967, the association was indebted to The Indiana National Bank of Indianapolis as follows:

Date of Note	Due Date	Interest Rate	Unpaid Balance
Mar. 15, 1966	Mar. 1, 1971	5½%	$ 5,883
Mar. 15, 1966	Mar. 1, 1971	5½	8,367
Total			$14,250

SUPPLEMENTARY DATA

Schedule A-1

INDIANA STATE MEDICAL ASSOCIATION

Analysis of Operating Expense—
Committees and Commissions—Officers and Council,
Year Ended September 30, 1967

	Actual	Budget
Committees and Commissions:		
Standing committees:		
Grievance	$ 161.00	$ 250
Student Loan	11.40	100
Future Planning	70.42	400
Commissions:		
Constitution	107.00	300
Inter-Professional Relations	236.00	300
Legislation	2,341.42	500
Public Health	449.40	400
Public Information	.....	300
Special Activities	298.55	300
Voluntary Health Agencies	303.44	500
Medical Economics and Insurance	609.72	500
Medical Education and Licensure	338.71	400
Governmental Medical Services	126.99	500
Aged	255.23	400
Education	13,001.77	12,000
Special programs and miscellaneous	4,686.19	5,000
Totals—exhibit A	$22,997.24	$22,150
Officers and Council:		
President	$ 4,205.70	$ 6,750
President-elect	624.80	750
AMA meetings	14,320.44	15,000
Treasurer's office—auditing	2,475.00	2,500
Council chairman and Council meetings	9,162.08	3,500
Executive Committee meetings	903.61	1,200
Totals—exhibit A	$31,691.63	$29,700

Schedule A-2

INDIANA STATE MEDICAL ASSOCIATION

Analysis of Operating Expense—Headquarters Office, Year Ended September 30, 1967

	Actual	Budget
Salaries	$ 74,421.11	$ 98,000
Telephone and telegraph	5,196.19	6,000
Postage	4,361.13	5,000
Printing and office supplies	5,660.97	6,000
Travel, entertainment and field expense	12,484.68	14,000
Building operations and utilities	8,674.28	12,000
Insurance	6,828.91	8,000
Extra help	72.50	500
Payroll taxes	2,610.48	3,500
Property taxes	7,244.64	7,000
Equipment maintenance	1,403.36	1,000
Depreciation	13,593.44	.....
Medicare expense in excess of reimbursement	9,872.68*	.....
Unallocated	621.58	1,000
	153,045.95	162,000
Less: Medicare expense reimbursement	.....*	15,000
Totals—exhibit A	$153,045.95	$147,000

* The actual figures reflect the medicare reimbursements as an offset against the related expense.

Schedule A-3

INDIANA STATE MEDICAL ASSOCIATION

Analysis of Operating Expense—Annual Meeting, Year Ended September 30, 1967

Convention planning	$ 248.79
Speakers' travel and expense	923.02
Technical exhibits, circulars, etc.	678.35
Scientific program and exhibits	678.35
Programs, handbooks and printing	2,659.56
Badges	185.40
Meetings—Council and House of Delegates	192.00
Telephone service	33.00
Office personnel expenses	623.66
Plaque awards	344.62
Prizes—annual meeting	123.95
50-year club	158.84
Photography	358.50
Banquet and party	840.00
Miscellaneous	3,869.00
	11,917.04
Less: Income received from exhibitors' booths	12,112.50
Excess of income over expense—exhibit A	$ 195.46

Schedule A-4

INDIANA STATE MEDICAL ASSOCIATION

The Journal Statement of Operations, Year Ended September 30, 1967

	Actual	Budget
Income:		
Subscriptions—members	$32,600.00	$31,506
Subscriptions—non-members	1,520.00	1,000
Advertising	50,926.27	40,000
Other	3,606.05	5,000
	88,652.32	77,506
Expense:		
Salaries, commissions and outside help	19,276.82	17,500
Printing and reprints	49,746.80	42,500
Engraving, art work and photographs	5,088.85	4,000
Office supplies and postage	545.98	600
Travel and meeting expense	1,684.19	1,800
Bulk mailing	1,455.61	.....
Other publishing expense	579.30	500
Payroll taxes	486.26	500
Rent and utilities	3,408.00	3,450
Telephone and telegraph	367.64	450
Insurance and retirement	690.75	750
Equipment replacement	.....	525
Miscellaneous	1,015.88	500
	84,346.08	73,075
Excess of income over expense—exhibit A	$ 4,306.24	$ 4,431

Chairman of the Council

May I first express my gratitude for the cooperation that the Council has had during the past year from the president, president-elect, treasurer and chairman of the Executive Committee. The Council could not effectively carry on its duties without the support and constant efforts of the headquarters staff. We are especially grateful to James A. Waggener, our executive secretary, for the long hours he spends in behalf of the Indiana State Medical Association. This is the twentieth year that Jim has been with our association, and we can consider ourselves fortunate for, at the various national meetings, the high regard other state executives and physicians from other states have for him is immediately apparent. The Council salutes you, Jim!

During the past year the Council has had six regular meetings—two more than is mandated by the Constitution and Bylaws. All of these meetings save one were two-day meetings. The increased number of meetings and the increased length in meetings has been the result of the volume of work and the complexity of the problems with which we have had to deal. It is a tribute to your present councilors that they have been so diligent in the execution of their duties and have given so freely of their own time to transact the business of our state association.

In March of this year the entire Council met in Washington, D.C. in regular session, and during this meeting interviewed the Congressional Delegation from Indiana. While the Council was in Washington, we also attended a National AMPAC Meeting which was most edifying.

In addition to the regular sessions, the Council committees have met regularly and diligently to perform the duties they have been assigned. These Council committees have developed considerable expertise in a variety of areas of specialization relating to organized medicine's role as a part of the total society. The chairmen of the Council committees are to be commended for the excellence of their activity and the volume of work they have accomplished.

I think there are three signal advances that have occurred in the past year in which the Council has assumed the leadership. The first is the reorganization of the reorganized IMPAC Board, Secondly, we have assumed the responsibility for acquainting the profession with the details of comprehensive health planning in Indiana. Every councilor has made a number of addresses to county society meetings in an effort to acquaint the membership with all the facets of comprehensive health planning and urge their cooperation. Lastly, our new computer billing system was established, and considering the rapidity with which this system was instituted, it has saved many man hours in the headquarters office and has streamlined the efficiency of our dues collection mechanism.

In view of the volume of work that seems to continuously increase, it is my recommendation that serious consideration be given to additional field staff. There are areas in which the councilors have extremely large districts and it is virtually impossible for them to actively practice medicine and also appropriately carry on their functions as councilors. Additional field staff would complement the duties of the councilors and would make for more efficient district medical societies.

Lastly, I should again like to recommend that the Constitution and Bylaws be changed to mandate six meetings a year for the Council. The Council introduced this resolution at the annual meeting last year but the Reference Committee to which it was referred recommended that a minimal change be made in the Constitution and Bylaws. Having served for two years as chairman of the Council, it is my opinion that it would be beneficial to require specifically that the Council meet at least six times a year.

LOWELL H. STEEN, M.D.,
Chairman

First Councilor District

The annual meeting of the First District Medical Society was held in Evansville, Indiana, May 23, at the Evansville Petroleum Club. A social hour, sponsored by Mead Johnson & Company, preceded the dinner. For their cooperation in the past, Mead Johnson's representatives were asked to dine with the First District.

Following the dinner, Mr. Bogdan Stronowicz gave a very informative talk on the subject of "Americanism." The guests were then introduced from the state organization —Dr. G. O. Larson, president, Dr. Patrick J.V. Corcoran, president-elect, and Dr. Donald Taylor, councilor for the Eighth District.

Dr. Patrick J.V. Corcoran and Dr. Gilbert Wilhelmus discussed the actions of the Council of the ISMA during the past year. Dr. George Willison gave a comprehensive report of the Indiana Blue Shield.

The following officers were elected by the First District:

President—Dr. Milton Anderson, Evansville

Vice President—Dr. James Hobgood, Evansville

Secretary-Treasurer—Dr. Fred Smith, Tell City

Councilor—Dr. Gilbert Wilhelmus, Evansville

Alternate Councilor—Dr. Eugene Austin. Evansville

A good portion of the First District members continue to be active in medical organizational matters and community affairs. A considerable amount of time has been spent on comprehensive medical planning.

The First District's dues were raised from $1 to $3.

GILBERT M. WILHELMUS, M.D., *Councilor*

Second Councilor District

During these past six to 12 months, there have been more revolutionary changes in the federal laws as to the way you can practice medicine than there have been in the past five years. The time spent by your county, district and state officers in meeting this challenge has tripled during this short period of time.

This is a very big statement to make. However, your elected officers and the many other volunteer physicians, on the various commissions and special committees of the Indiana State Medical Association, will tell you that it is a factual statement.

Your Council has been very active this past year. We had one Council meeting in Chicago and while there made a tour of the AMA Building, noting how it functioned and its activities. There was also a national workshop of AMPAC at Washington, D.C. which we attended.

The Federal Government, a long time ago, put its foot in the door and many legislators will not be satisfied unless they get themselves all the way in and set up total control of, not only physicians, but also the control of hospitals, nurses and any agency that has anything to do with health. In other words, Federal Socialized Medicine should be spelled with capital letters and not the little tiny letters they would lead you to believe they are using now.

The time has come for every physician to stand up and be counted in the defense of his profession if he wants the practice of medicine to survive as we know it today. You can help by:

1. Taking a little time out of your heavy and busy practice to attend your local, county and state business meetings, so that you may become a little more knowledgeable about what is going on in organized medicine to meet this challenge.

2. Taking an active part in organized medicine. We need new physicians with new ideas, talents and energies. Pick out one of the commissions or special committees that you would like to work on, let me know, and I will see that you are appointed. Your state president, with the recommendation of your councilor, makes these appointments.

3. Contribute your monies to AMPAC and IMPAC and help elect legislators that are sympathetic to the type of legislation which supports the objectives of the profession. The one statement that I heard over and over, when attending the national workshop of AMPAC at Washington, D.C. was, "HELP ELECT CONGRESSMEN AND SENATORS FROM YOUR STATE AND DISTRICTS THAT ARE SYMPATHETIC TO THE PRACTICE OF MEDICINE AS WE CARE AND CONCEIVE IT SHOULD BE MAINTAINED." Start at the grass roots. Much more can be done at home by electing the representative that we want, and letting him carry out our ideas in Washington, D.C., than can be done by lobbying at the same address.

I would also like to emphasize, first, that we can do more as a group than we can do as individuals. Secondly, get interested in local politics and be a leading citizen as this is truly an obligation of yours.

Let me urge you to take time out to read and reread both your county and state Constitutions and Bylaws. In the very near future, a booklet will be mailed to you stating what the state medical association will and is doing for you. You will be amazed at what your state society is attempting to do, even if you read no more than the preamble.

I would like to pose one more additional idea to you, and that is the thought that to make the district more effective, it needs a common office with adequate help. As of now, the burden of responsibility falls on the volunteer efforts of the district society officers, with occasional assistance from our field representative and the state office.

If we are to function effectively as a cohesive, active unit of district physicians of which there are 145, it is my sincere belief that we need committees to function, we need facts and information, and we need additional paid staff to assist us in coordinating and correlating administrative and public relations functions with our district and county societies and the state headquarters.

For your information, the Indiana Hospital Association is expanding its staff through a grant from Blue Cross, which, to say the least, will make IHA a more effective force in dealing with hospital problems and make the Indiana Hospital Association a more forceful unit to Indiana patient care. I think it is something for us, as physicians, to give some serious thought.

The district meeting was held in Bloomington May 23, 1968. The alternate councilor and Blue Shield representative were elected. Dr. J. Stanley Brown was elected secretary for the 46th time.

JOSEPH E. DUKES, M.D., *Councilor*

Third Councilor District

Activities of the organization of medicine in the Third District were, in general, increased over last year. This was in large part due to the impetus of the Comprehensive Health Planning Law (PL 89-749). Most of the county societies in the district participated to some extent in attempting to be a part of the local planning council. As usual, there was not unanimity of opinion as to the wisdom of participating.

The annual meeting was held at New Albany on May 15 at the Robert E. Lee Motel with a program on lung and bowel cancer through the courtesy of the Cancer Society and the after dinner program by Dr. George Lukemeyer, Associate Dean of the Indiana University Medical Center, speaking on the heart-cancer-stroke regional program. Dr. Daniel Cannon of New Albany was re-elected district society president. An excellent program was presented for the ladies.

There were no major membership problems through the year, but a significant law

suit is now in progress which might have been averted, or at least modified, had the local grievance committee been active and functioning. I would urge all districts to be cognizant of the significant potential of these committees and press for their vigorous functioning.

DONALD M. KERR, M.D., *Councilor*

Fourth Councilor District

The Fourth District Medical Society annual meeting was held in Seymour on May 15, 1968. Attendence was fair. A combined scientific and general interest program included Donald Girod, M.D., Robert Yoho, Ph.D., and the Honorable Edgar D. Whitcomb as guest speakers. The district was further pleased to have Lowell Steen, M.D., chairman of the Council of the ISMA, as a guest.

The delegate meeting considered at some length the seemingly endless problem of maintaining communications and interest within this geographically large area. As a token approach to improvement, a resolution requiring a ten dollar ($10.00) payment annually from each district member was passed. This money is to be used to assist the councilor in maintaining better contacts among the membership. It is hoped that such funding will permit the employment of a part-time executive secretary. Further it is planned to divide the district into two geographic areas—each of which will be in closer contact with a physician designated by the councilor.

The new district officers included William Freeland, M.D., president and Robert M. Reid, M.D., councilor.

The district has begun the informal exploration of means to make available within this area the various innovations in technology which would promise to deliver good medical care more economically. The particularly distressing shortage of physicians in this district provides special impetus to such a study. It is considered unfortunate that too often the application of such potential improvements in medical care is introduced by agencies outside the private sector of medicine. Of particular interest is the possible application of the various multiphasic computerized analyses which may prove to be suitable to our problems.

The councilor invites suggestions and comments from other ISMA members who are interested in this significant development in medicine.

ROBERT M. REID, M.D., *Councilor*

Fifth Councilor District

The annual meeting of the Fifth District Medical Society was held April 3, 1968 at the Terre Haute Country Club. A business meeting was held at 4:00 p.m. with approximately 30 members present. There were four commission members from the Fifth District present who gave reports on the activities of their commissions. Also attending were: Dr. P.J.V. Corcoran, president-elect of ISMA, Mr. James A. Waggener, executive secretary and Mr. Robert Amick, field secretary.

A group discussion was held on Comprehensive Health Planning. It was unanimously decided that the doctors should participate in Comprehensive Health Planning and some of the objectives were explained.

Officers elected were: J. W. Somerville, M.D., Clinton, president; Milton Herzberg, M.D., Clinton, secretary; and Fred Dierdorf, Terre Haute, Blue Shield Board member to replace Dr. H. T. Goodman who has been a member for several years and has done a very competent job.

The Parke-Vermillion group invited the Fifth Medical District group to hold their meeting in Parke-Vermillion next year.

After the business meeting Dr. P.J.V. Corcoran gave a very enlightening speech entitled "Future of Medicine."

Dinner was served at 7:00 p.m. to approximately 50 members.

WILBERT McINTOSH, M.D., *Councilor*

Sixth Councilor District

The Fayette-Franklin County Medical Society and auxiliary were host to the Sixth District Medical Society annual meeting held May 1, 1968 at the Connersville Country Club. There was an Indiana Academy of General Practice Road Show held in conjunction with this meeting. Thanks go to Mrs. Jackie Schilling and her secretary for their help with mailings, speakers and reservations.

The business meeting was called to order by Dr. Paul Inlow. Dr. Frank Green was voted to succeed himself as the Sixth District representative on the Blue Shield board.

Dr. David Wynegar, Richmond was selected secretary-treasurer for the coming year. The date and place of the next meeting will be announced by the new secretary. The other officers for the coming year are president—Stephen D. Smith, M.D., Knightstown and vice president—Perry F. Seal, M.D., Brookville.

Mr. Waggener of the Indiana State Medical Association encouraged all counties to set up the county Comprehensive Health Planning Committee to be recognized by the State Board of Health.

Dr. Wilson Dalton pointed out the qualifications and candidacy of Dr. Otis Bowen as a candidate for Governor.

Mr. F.D. Harbridge, Blue Shield representative, discussed the latest changes in Medicare.

Dinner was served at the Connersville Country Club to 43 members and guests.

STEPHEN D. SMITH, M.D., *Councilor*

Seventh Councilor District

The annual meeting of the Seventh District Medical Society was held at 7:00 p.m., Wednesday, May 15, 1968, at the Hillview Country Club, in Franklin, Indiana, with the president, Dr. Harry E. Mock, Jr., of Franklin, presiding.

By consent, it was voted to dispense with the reading of the minutes of the previous meeting.

In the absence of Dr. James H. Gosman, of Indianapolis, secretary-treasurer, Mr. Arthur G. Loftin, the society's executive secretary, presented his report showing a bank balance of $1,061.32, as of May 15, 1968. He announced that officers of the society had agreed that the society defray the cost of the dinners served preceding the meeting.

Dr. Mock then called for nominations for president-elect of the society to serve in 1969-70. Dr. William D. Province, of Franklin, nominated Dr. Malcolm O. Scamahorn, of Pittsboro, and Dr. Hugh K. Thatcher, of Indianapolis, with several seconds, moved that the nominations be closed. The motion was carried and Dr. Scamahorn was declared elected unanimously.

Dr. Mock then called for nominations for secretary-treasurer. Dr. John O. Butler, of Indianapolis, nominated Dr. Donald E. Stephens, of Indianapolis, and Dr. Province, with many seconds, moved that the nominations be closed. The motion was carried and Dr. Stephens was declared elected unanimously.

Dr. Mock asked for nominations for councilor from the district to the Indiana State Medical Association. Dr. Scamahorn moved that the nominations be closed and that Dr. Gosman be declared elected unanimously. The motion was carried.

Dr. Mock then introduced Dr. Albert M. Donato, of Indianapolis, retiring Seventh District councilor, who discussed

the provisions of the Comprehensive Health Planning law and urged physicians to play a strong role in establishing comprehensive health planning committees in each county.

Following distribution of golf prizes by Dr. John M. Records, of Franklin, the meeting, by consent, was declared adjourned by Dr. Butler, who began his term of office as president.

This marks my final report as Seventh District councilor, after having served six years. It has been an exacting, but rewarding, duty. I have been impressed with the sincerity and concern of the Council members and with their responsible decisions in matters of importance to all of medicine in Indiana. Personally, I should like to think that I have helped to alert you to some of the extremely serious problems facing us. It has been a great privilege to represent you.

ALBERT M. DONATO, M.D.,
Councilor

Eighth Councilor District

The annual meeting of the Eighth District Medical Society was held at the Country Club in Anderson on June 5, 1968. The meeting was under the direction of Dr. William Stinson, president and Dr. Charles King, secretary-treasurer, both of Anderson.

The afternoon was devoted to social activities by the membership, auxiliary and guests. Dinner was served to approximately 80 members and guests. Mr. Stan Evans, editor, *Indianapolis News* was the after-dinner guest speaker.

At the society business meeting, many problems currently facing organized medicine were discussed. The impact of Public Law 89-749 on the practicing physician was brought to the attention of the society by the district councilor.

Dr. Fletcher McDowell, the Eighth District Blue Shield Director, talked briefly on Blue Shield problems and programs during the past year.

The society voted to increase the membership dues for the district society to $2.00 per member per year. This increase will be carried on the billings for next year.

The 1969 meeting of the society will be held in Muncie on June 4, 1969. Dr. Francis Stout was elected president and Dr. Richard Philbert, secretary-treasurer for the coming year. Both officers are from the Delaware-Blackford County Medical Society.

DONALD R. TAYLOR, M.D.,
Councilor

Tenth Councilor District

The Tenth District held two well-attended meetings during the past year. The first meeting was held at the Sheraton Motel in Gary, Indiana on October 4, 1967. Dr. R. J. Bills of Gary, president of the Tenth District, presided at this dinner.

Dr. G. O. Larson, president-elect, Dr. Donald M. Kerr, Third District councilor, Mr. Howard Grindstaff, field representative of the Indiana State Medical Association, and Dr. Peter Pilecki, president of the LaPorte County Medical Society, along with several members of the LaPorte county society, were present and were introduced. Several police and Civil Defense officers from the communities in Lake County were in attendance and were introduced.

D. W. Lindner, M.D., chairman of the Detroit Medical Society Disaster Committee, and Lt. Anthony Bertoni of the Detroit Police Department, presented an illustrated description of their experiences during the civil disorders in Detroit in July, 1967. They urged careful planning in the Lake County area to better prepare the physicians and the community to handle any similar problems which might possibly occur here. This meeting was planned in anticipation of possible civil disorder in conjunction with the November, 1967, elections. There were many questions by those present and a long discussion followed the presentation.

An election of Tenth District officers was held and resulted in the election of J. J. Reed, M.D. of Hobart, president, and Ray Doherty, M.D. of Crown Point, secretary.

The second meeting for the year was held on May 1, 1968 at Phil Smidt's in Whiting. The meeting was attended by 120 doctors and wives. Raymond J. Doherty, M.D., secretary of the Tenth District society, presided. Seymour W. Shapiro, M.D., Lake County Medical Society president, Herman Wing, M.D., alternate councilor for the Tenth District, J. J. Reed, M.D., president of the Tenth District, Howard Grindstaff, field secretary to the Indiana State Medical Association, Herb Dixon, vice-president and Physicians Relations Director of Indiana Blue Shield, and G. O. Larson, president of Indiana State Medical Association, were introduced.

Lowell H. Steen, M.D., councilor for the Tenth District, presented Otis Bowen, M.D. of Bremen, Indiana, candidate for Governor and Speaker of the House of Representatives of the Indiana General Assembly. Dr. Bowen delivered an informative and interesting discussion of the state's major legislative problems and dissertation on the physician's responsibility as a citizen. He answered a number of questions from the membership.

Milton B. Gevirtz, M.D., Tenth District director of the Indiana Blue Shield Board, discussed comprehensive health planning and a plan for the establishment of a broader program of activity for the county medical society. He also discussed a foundation for the assistance of students in medicine and the windows and orphans of deceased and disabled members.

Dr. Steen introduced G. O. Larson, M.D., president of the Indiana State Medical Association, who made a strong appeal for wider participation by physicians in their county and state medical associations. He expressed his appreciation for support given him by many physicians in Lake County.

During the past year we are delighted to see the revitalization of the Porter County Medical Society. This society has been relatively dormant for the past five to six years. There has been new blood infused and they appear to be an active, going group. It is hoped that their activities will continue and that their vigor and ardor will not cool with time.

LOWELL H. STEEN, M.D.,
Councilor

Twelfth Councilor District

The Twelfth District is undergoing a reorganization. We are trying to improve the communication between the councilor, the various county medical societies and the voice of each member of the Twelfth District in his personal feelings as to the course of organized medicine. We have had many meetings of the combined societies and I have met with all but two of my county societies on separate occasions. These meetings have been very productive not only in helping the local societies in better understanding the paramount issues of the day, such as comprehensive health planning, and the place the county medical society has in the state medical organization, but also in some advancement in getting more men (both young and old) interested in organized medicine. We hope to stimulate this interest so that the practice of medicine as we know it today will continue to exist and that we physicians will be leaders in our own destiny.

We hope to expand the activity of the Twelfth District by creating a new central committee, called the board of directors. The members of this board will be comprised of the regular elected Twelfth District officers, the various county society officers, delegates and alternate delegates. This board will meet at least four times a year and more often if needed. Better

communication through these meetings will be obtained between district officers and county officers. It will enable the councilor and the delegates to better represent the wishes of the district at the state level. It is felt that we will be more able to coordinate the activities of the district in meeting the rapidly changing policies in governmental medical problems.

The annual meeting was held May 15th at Eaton Springs Trout Club, Angola, Indiana. New officers were named — Kenneth Isenogle, M.D., Fort Wayne, president; A. L. Fipp, M.D., Rome City, vice president; John J. Hartman, M.D., Angola, secretary-treasurer. Fred Schoen, M.D., was elected alternate councilor for a three-year term. A motion for the reorganization of the district was made, and after many expressions of supporting sentiments, the motion was unanimously adopted.

Reports were given by the officers and a typewritten report of my activities as councilor was made available to all in attendance. This report and other reports of the state Council activities were mailed to the various counties of the district.

That evening we were treated to a fine, humorous and enlightening address by Dr. Henry M. Johnson—"Maximum Matrimonial Milage with Minimum Misery" or How to be Happy Although Married. I thank the Steuben County Medical Society for being such excellent hosts. My thanks also go to the outgoing officers of the district for their fine leadership and cooperation during the past year. I also want to thank Dr. Fred Schoen, my alternate, not only for his fine counsel in state problems but also for his aid and leadership in the problems of reorganization of the district.

I, along with the officers of the district, look forward to the challenges of the new year. With their help, I sincerely hope that I can successfully meet the challenges of the rapidly changing times of the practice of medicine, both politically and in the betterment of health services to our patients.

WILLIAM R. CLARK, Sr., M.D., *Councilor*

Thirteenth Councilor District

President Edwin C. Mueller and his committee have had several planning sessions in preparation for the Thirteenth District's annual meeting.

The meeting will be held on September 11, 1968 at the Red Lantern Inn in Beverly Shores near Michigan City.

There will be four separate sessions as follows:

3:00 p.m. to 5:00 p.m.—Speakers to be furnished by the Indiana State Medical Association and the American Medical Association. Their topics will be pertinent to all interest groups of organized medicine.

5:00 p.m. to 6:00 p.m.—Business meeting.

6:00 p.m. to 7:00 p.m.—Cocktail hour.

7:00 p.m.—Banquet. Speaker, obtained by the president of the Indiana State Medical Association, Dr. G. O. Larson, is Mr. Calvin Johnson, Director of Customer Relations of Remington Rand Division of Sperry Rand Corporation and a former member of the United States Congress from Illinois.

For the ladies: There will be a dessert and fashion show held at the Holiday Inn in the afternoon.

OTIS R. BOWEN, M.D., *Councilor*

Editor of The Journal

The Journal is enjoying a satisfactory financial year. With three-fourths of the fiscal year on record, our receipts from dues and advertising are about as predicted and the receipts from non-members and all other income items are slightly ahead of the budget.

The printing bill is a little over expectations as is the expense for engraving. We should end the year with a slight excess of revenue over expenditures.

Medical journal advertising is off the country over. The slump involves the big nationally circulated journals, both medical society oriented and commercial, as well as state journals. It is apparently due to the fact that there are fewer new drug products being introduced, to narrowing profit margins in the pharmaceutical industry and to difficulty, on the part of the industry, to interpret correctly the new standards for drug advertising as advanced by the Food and Drug Administration.

These conditions will probably continue for some time. Our journal will attract advertising in proportion to the response which our readers demonstrate to the advertisers. All readers, and especially delegates and officers of the association, should make it a habit to write some advertiser each month to compliment the advertising message and the information it contains or to thank him for supporting *The Journal*.

Thanking the advertisers need not be a time-consuming task—a note on a prescription blank, addressed to the president or advertising manager will accomplish wonders in selling advertising space. Our journal has done extremely well this year in maintaining its advertising revenue in the face of a falling market—we can continue to do so by letting the advertisers know that their messages are being read.

The Editorial Board and the Associate Editors have continued this year to enlarge the scientific content of *The Journal* with scientific material prepared especially for us by the members of the faculty of Indiana University School of Medicine. This year has seen the beginning of a regular Clinicopathologic Conference. We have, each month, a short article on a single therapeutic subject. It is planned to add a monthly page or two on a pediatric subject in the near future.

FRANK B. RAMSEY, M.D., *Editor*

Delegates to AMA

Indiana State Medical Association officials and delegates to the 117th annual convention of the American Medical Association considered, debated and voted on issues presented to the House of Delegates of the AMA June 16 through June 20 in San Francisco.

Decisions by this policy-making body of the association involved careful consideration and scrutiny of 85 resolutions introduced by the various state delegations, 39 reports of the AMA Board of Trustees and 19 Council and committee reports.

In preparation for the AMA meeting, the Council of the Indiana State Medical Association met in a day-long special session on Sunday, June 9, to consider the advance Board of Trustees' reports and 48 resolutions with the objective of advising ISMA delegates of the official position of ISMA on the reports and resolutions. In many instances, because of the nature of some resolutions, the Indiana delegation was directed to use their best judgment on their votes in the house. The Council recommended opposition to eight reports and resolutions and amendments to five others.

Dr. Guy A. Owsley of Hartford City was elected chairman of the delegates. Other delegates in attendance at the meeting included Drs. Don E. Wood and Dwight W. Schuster, both of Indianapolis; Eugene F. Senseny, Fort Wayne and Frank H. Green, Rushville.

Alternate delegates in attendance included Drs. Robert M. Brown, Marion; Kenneth O. Neumann, Lafayette, and Maurice E. Glock, Fort Wayne. Acting as alternates, in the absence of Dr. Jack Shields of Brownstown, and Dr. Harold Ochsner of Indianapolis, were Dr. Lowell Steen, Hammond, chairman of the ISMA

Council and Dr. P. J. V. Coreoran, ISMA president-elect.

To keep abreast of current daily changes in the business of the house, Dr. G. O. Larson, LaPorte, ISMA president, called a June 15 meeting and three breakfast meetings of offieials and delegates to hear reports, decide on reference committee assignments and other actions.

Meeting with this group to assist were Drs. Ralph V. Everly, Indianapolis, chairman, ISMA Exccutive Committee; Burton E. Kintner, Elkhart, member, Executive Committec; Lester H. Hoyt, Indianapolis, treasurer of the assoeiation; M. O. Scamahorn, Pittsboro, assistant treasurer; Lall G. Montgomery, Muncie, delegate from the AMA Section on Pathology and Physiology; Sprague H. Gardiner, Indianapolis, alternate delegate from the AMA Scction on Obstetries and Gynccology, and Lester D. Bibler, Indianapolis, AMA Board of Trustees.

Elections

Despite an all-out effort by the Indiana delegation to retain Dr. Lester Bibler as a member of the AMA Board of Trustees for his final term, Dr. Bibler lost to Dr. Raymond T. Holden of Washington, D.C. by a narrow margin. The only incumbent retained in four elections for the board was Dr. L. D. Simenstad of Wisconsin. The two other trustees elected were Dr. John M. Chenault, Alabama and Dr. John R. Kernodle, North Carolina.

In other action by the House of Delegates, Dr. Gerald D. Dorman of New York was named president-elect of AMA and Dr. Dwight L. Wilbur of San Francisco assumed the offiee of president for 1968-1969. Dr. Carl A. Lincke, Ohio, was elected vice-president; Dr. Walter C. Bornemeier, Illinois, was re-elected to the office of speaker of the house and Dr. Russell B. Roth was returned to his post as vice-speaker.

Dr. Francis Land, former Fort Wayne physician, was re-elected to the Council on Medical Education.

Also of interest to the Indiana delegation was Resolution 47, introduced by Indiana in Houston in 1967, and subsequently referred to the Board of Trustees for study.

The resolution asked that the appropriate department of AMA prepare, cause to have introduced and work for the passage of federal legislation to deelare doetors exempt from any federal requirements of an interstate commerce nature.

In Report M of the Board of Trustees which resulted from the board's investigation it was pointed out that "The legal issue actually involved is whether employees in a physician's office who are not licensed physicians are entitled to the benefits of the Fair Labor Standards Act, which establishes minimum wage, overtime pay, record keeping and other standards for most of the employees in the company. . . ." Report M also stated that ". . .the Legal Research Department is convinced that employees in the physicians' office are not covered by the FLSA."

The Law Division of AMA and the board agreed, however, that the most appropriate action of Resolution 47 is to 1) furnish general information on the question of FLSA coverage; 2) urge that physicians voluntarily adopt minimum wage, overtime pay and record keeping practices equal to those established by FLSA; and 3) recommended that any physician confronted by a claim that his employees are covered by the FLSA consult his attorney for the purpose of resisting that claim. The ISMA Council, at its June 9 meeting had already moved to support this report.

Other Actions

In pinpointing some of the other actions of the house from the immense volume of business which was undertaken, the delegates:

—Were advised that a full day working conference on comprehensive health planning has been scheduled for November 30, 1968 in Miami Beach immediately before the 1968 Clinical Convention.

—And that a handbook on comprehensive health planning is nearing completion and will include some "tactical" suggestions to medical associations for effective participation in planning.

—Referred Resolution 74 on Health Care Financing to the Board of Trustees with the recommendation that the AMA approve in principle a graduated income tax credit for health insurance premiums paid out for adequate medical and hospital services coverage.

—Strongly disapproved of the provision of funds by the Federal Government to subsidize any one form of medical practice.

—Resolved that the AMA request the secretary of Health, Education and Welfare to continue to solicit the advice and counsel of those practicing physicians designated by their medical associations at the local, state and national level, in formulating future plans and programs and in modifying existing programs, in order to provide the best quality health care for the people of the United States.

—Asked the AMA to arrange for a new draft of standards of the Joint Commission on Accreditation and circulate the draft to state medical associations for comment before final adaptation.

—Resolved that the House of Delegates continue to urge that adequate representation of the medical staff on the voting membership of the hospital's governing body is the most effective mechanism for assuring a working communication provided that physicians serving on the governing board be nominated by the medical staff of the hospital.

—Adopted a portion of a lengthy report by the Board of Trustees on infant mortality and urged state and component societies to evaluate existing maternal and child care resources and take leadership in the expansion and development of programs for delivering services in locations found to be deficient. (ISMA Council has directed that this report be made to the House of Delegates of ISMA in October).

—Cited erroneous information contained in "A Report on Laboratory Performance and Methods for Improvement" published by the Department of Health, Education and Welfare in June, 1967 and requested the AMA to advise HEW that errors were made in the report and published in *The Congressional Record*, and that the secretary of HEW be asked to respond.

—Urged the AMA to continue its efforts to safeguard and inform the medical profession and the public with respect to the treatment of obesity.

—Reaffirmed the previous policy of the AMA to eliminate recertification in P. L. 89-97.

—Approved a resolution that "The bylaws of the AMA be amended to provide that in addition to receiving 'appeals filed by applicants who allege that they, because of color, creed, race, religion or ethnic origin, have been unfairly denied membership in a component and/or constituent association,' determining facts and reporting its findings to the House of Delegates, the Judicial Council shall, if it determines the allegations are indeed true, admonish, censure or, in the event of repeated violations, recommend to the House of Delegates that the state association involved be declared to be no longer a constituent association of the American Medical Association."

—In the area of reducing costs to patients, adopted a resolution that "the AMA endorse the principle of voluntary health insurance coverage for outpatient x-ray and laboratory services acceptable to the hospital and its medical staff wherever performed prior to a scheduled hospital admission;" and adopted another resolution that "all insurance companies and fiscal intermediaries" adopt and authorize the use of standard forms in conjunction with a single hospital admission to save physicians' time and expense.

—With respect to relationships and negotiations between the AMA and the osteopaths, accepted for information a Board of Trustees report which stated "In the absence of cooperative leadership on the part of the practicing osteopaths and osteopathic educators, accomplishments by the AMA are rendered difficult. Such leadership was forthcoming in California, and is now needed elsewhere. When this osteopathic leadership is developed, the AMA stands ready to cooperate to its utmost."

—Voted to "participate in a program of planning and action with other organizations concerned with architectural barriers to the handicapped" and requested state and county medical societies to encourage their members to become active in helping to alleviate such barriers.

—Referred to the AMA's policy on chiropractic and urged state and local medical societies "to formally adopt the AMA Policy Statement on Chiropractic, or a somewhat similar expression" and "to alert the general public to the health hazard posed by the cult of chiropractic."

—Adopted a Judicial Council report on "Ethical Guidelines for Organ Transplantation." One of several important guidelines was, "When a vital, single organ is to be transplanted, the death of the donor shall have been determined by at least one physician other than the recipient's physician. Death shall be determined by the clinical judgment of the physician. In making this determination, the ethical physician will use all available, currently accepted scientific tests."

—Referred to the Board of Trustees a resolution to establish a joint commission on accreditation of nursing schools, with participation by the AMA, American Hospital Association, American Nurses Association and National League for Nursing.

GUY A. OWSLEY, M.D.
JACK E. SHIELDS, M.D.
HAROLD C. OCHSNER, M.D.
EUGENE F. SENSENY, M.D.
FRANK H. GREEN, M.D.

Starting in October!

New series on Aviation Medicine — watch for it!

Reports of Committees

Executive Committee

In the past it has been customary for the Executive Committee to skim the activities of its various meetings in this report to the House. In order not to burden the House and the Reference Committee, the report this year will be condensed.

During the course of the past year, the minutes of the meetings of the Executive Committee have been published in *The Journal* so that the members have had an opportunity to review the transactions of your committee. We have presented a complete set of minutes for the year to the Reference Committee for their review. We believe this should constitute a more readily understandable report of the activities of your committee.

There are a few matters to which special attention should be called. One is that the association is now completely out of debt on all of its real estate holdings and has rented the properties on the Pennsylvania Street side; these have been rented since the association took title to the properties.

The committee met regularly each month during the year to transact the routine business of the association and to handle matters of housekeeping as well as requests of individual physicians, committees and commissions.

We hope the brevity of this commentary will not reflect inactivity on the part of the committee. As we said before, the committee has met monthly and the average committee meeting consumes some six to eight hours time on the part of the members.

Medical Defense Activities

1. *Malpractice Cases.* A year ago, at the time of this report, August 1, 1967, the following three cases were pending before the committee:

Case 307 — Suit filed March 22, 1962. Pending. (Expense to date, $1,042.73).

Case 309 — Suit filed December 10, 1964. Pending.

Case 312 — Suit filed December 7, 1965. Pending.

Since August 1, 1967, and up to August 1, 1968, the following new case has come before the committee, making four cases pending at this time as against two unclosed cases at the same time last year:

Case 313 — Suit filed September 5, 1967.

2. *Medical Defense Fund Statement from August 1, 1967 to August 1, 1968.*

Bank balance, August 1, 1967		$1,745.08
Receipts:		
Dues	$4,976.25	
Interest	975.00	
Treasury Bills	2,700.00	
Reimbursed Attorney Fees	2,096.25	
(Charged to General Fund)		
		10,747.50
Total cash and receipts		$12,492.58
Disbursements:		
Attorney Fees	$4,200.00	
Reimbursement for Legal Defense	5,138.79	
Total Disbursements		9,338.79
Balance on hand, August 1, 1968		$ 3,153.79

MEMBERSHIP REPORT

	Dec. 31, 1967	July 31, 1967	July 31, 1968	AMA, 1968
1st District				
Gibson	13	13	12	12
Perry	8	8	8	8
Pike	3	3	3	3
Posey	8	8	8	8
Spencer	4	4	4	4
Vanderburgh	233	232	230	226
Warrick	7	7	6	6
TOTAL	276	275	271	267
2nd District				
Daviess-Martin	21	21	20	15
Greene	13	13	14	10
Knox	41	41	40	38
Owen-Monroe	72	72	78	73
Sullivan	13	13	14	12
TOTAL	160	160	165	148
3rd District				
Clark	41	40	42	41
Dubois	23	23	23	20
Floyd	39	39	41	39
Harrison-Crawford	11	11	10	10
Lawrence	25	25	25	21
Orange	9	9	9	9
Scott	5	5	6	6
Washington	7	7	8	8
TOTAL	160	159	165	154
4th District				
Bartholomew-Brown	51	51	52	50
Dearborn-Ohio	18	17	17	16
Decatur	9	9	10	9
Jackson-Jennings	25	25	23	22
Jefferson-Switzerland	23	23	26	25
Ripley	8	8	7	5
TOTAL	134	133	135	127
5th District				
Clay	14	14	14	14
Parke-Vermillion	22	22	18	18
Putnam	16	15	16	16
Vigo	114	113	115	115
TOTAL	166	164	163	163
6th District				
Fayette-Franklin	16	16	14	14
Hancock	22	22	23	23
Henry	38	38	39	39
Rush	15	15	12	12
Shelby	19	19	19	17
Wayne-Union	70	70	72	70
TOTAL	180	180	179	175
7th District				
Hendricks	20	20	20	20
Johnson	30	30	32	32
Marion	1080	1053	1058	1049
Morgan	20	20	19	18
TOTAL	1150	1123	1130	1120
8th District				
Delaware-Blackford	119	118	113	108
Jay	16	16	16	13
Madison	102	102	107	77
Randolph	19	19	18	14
TOTAL	256	255	254	212
9th District				
Benton	8	8	9	9
Boone	21	21	22	21
Clinton	20	20	18	18
Fountain-Warren	14	14	12	12
Hamilton	18	18	18	16
Montgomery	23	23	24	24
Newton	5	5	5	5
Tippecanoe	134	134	135	131
Tipton	11	11	11	11
White	10	10	9	9
TOTAL	264	264	263	256
10th District				
Jasper	7	7	7	7
Lake	443	418	439	414
Porter	43	43	49	46
TOTAL	493	468	495	467
11th District				
Carroll	8	8	9	9
Cass	32	32	31	28
Grant	72	69	69	69
Howard	70	70	67	67
Huntington	21	21	20	20
Miami	11	11	13	13
Wabash	27	27	29	29
TOTAL	241	238	238	235
12th District				
Adams	15	15	14	14
Allen	292	292	297	293
DeKalb	23	23	22	22
LaGrange	9	9	8	8
Noble	16	16	15	15
Steuben	13	13	12	12
Wells	47	47	44	44
Whitley	17	17	17	17
TOTAL	432	432	429	425
13th District				
Elkhart	113	111	112	109
Fulton	10	10	11	10
Kosciusko	17	17	18	18
LaPorte	98	96	97	88
Marshall	25	25	26	26
Pulaski	5	5	4	3
St. Joseph	235	234	239	238
Starke	6	6	6	6
TOTAL	509	504	513	498
SUMMARY				
1st District	276	275	271	267
2nd District	160	160	165	148
3rd District	160	159	165	154
4th District	134	133	135	127
5th District	166	164	163	163
6th District	180	180	179	175
7th District	1150	1123	1130	1120
8th District	256	255	254	212
9th District	264	264	263	256
10th District	493	468	495	467
11th District	241	238	238	235
12th District	432	432	429	425
13th District	509	504	513	498
TOTAL	4421	4355	4400	4246

The Journal

Activity in advertising shows an increase in revenue for the first six months of 1968 as compared with the first six months of 1967. The financial condition of *The Journal* continues to improve but we must be cautious in leaving the impression that this may continue over an indefinite period of time. The advertising program of the pharmaceutical companies and others is still in a state of readjustment and we may see a slight decrease in the coming months in our advertising revenues.

With the increased amount of advertising which we have carried, and which requires extra pages for printing, it appears that the printing cost for the year 1968 will be approximately $5,000 more than for the year 1967.

Listed below is a comparative report of

The Journal operations over the past several years and the first six months of 1968.

This is a comparative report for the first six months of each year indicated.

1965	1966	1967	1968
State Journal Advertising Bureau $13,927.88	$18,063.54	$23,468.96	$24,153.24
Sold Direct by Journal 2,812.74	2,687.76	3,056.68	7,200.10
Total $16,740.62	$20,757.30	$26,525.64	$31,353.34

Printing Costs

Year	Cost	No. of Pages (Inserts excluded)
1964	$36,139.47	1456
1965	35,957.50	1416
1966	41,795.32	1410
1967	49,958.15	1450
1968 (6 months)	27,682.74	562

Year	Reading	% Reading	Adv. Pages	% Adv. Pages	Total Pages	Av. Pages per Issue
1962	1308	68	604	32	1912	159
1963	1139	70	487	30	1626	135
1964	1051	71	423	29	1474	123
1965	998	68	464	32	1462	122
1966	789	50	781	50	1570	131
1967	1041	58	751	42	1792	149

RALPH V. EVERLY, M.D., *Chairman*
BURTON E. KINTNER, M.D.
G. O. LARSON, M.D.
P. J. V. CORCORAN, M.D.
LOWELL H. STEEN, M.D.
LESTER H. HOYT, M.D.
MALCOLM O. SCAMAHORN, M.D.

Grievance Committee

The Grievance Committee held meetings on November 5, 1967, and February 11, 1968.

As of July 1, 1968, 19 cases were considered during the year. Of these, six cases were settled by physician and patient, with five cases referred to the county medical society and settled. Thus eight cases remain on the docket of the ISMA Grievance Committee pending settlement.

As usual a number of other complaints were received which were not accepted as cases by the Grievance Committee. These include grievances where the complainant declines to be identified or where preliminary study reveals no violation on the part of a physician but is rather a complaint as to hospital charges, drug costs, insurance coverage, etc. Explanatory letters are sent to all complainants.

The Grievance Committee as a first step in handling a seemingly legitimate complaint encourages the physician charged to attempt a friendly discussion with the complainant. If this approach is unavailing, we persist in our effort at local adjudication by asking the county medical society to attempt resolution of the problem. When this effort fails, or when local adjudication is declined, your state Grievance Committee proceeds to act as directed by the 1951 House of Delegates in the interest of public and professional relations.

The 1967 House of Delegates directed that the publication, *Purposes, Rules and Procedure of the Board of Appeals on Patient-Physician Relations (the Grievance Committee)*, approved by the Council on April 26, 1952, be brought up to date. Legal counsel for the Indiana State Medical Association conferred with the Grievance Committee and this work has gone forward. The revised document will be presented for correction or ratification before being printed and distributed as directed to all members of the ISMA.

The Grievance Committee has again enjoyed excellent co-operation from many members of the Indiana State Medical Association.

PHILIP B. REED, M.D., *Chairman*
EUGENE S. RIFNER, M.D., *Vice-Chairman*
ROBERT G. YOUNG, M.D., *Secretary*
KENNETH L. OLSON, M.D.
EARL W. MERICLE, M.D.
RICHARD BLOOMER, M.D.
JOHN M. PARIS, M.D.
WILSON L. DALTON, M.D.
WILLIAM R. NOE, M.D.

Student Loan Committee

The Student Loan Committee held five meetings during the past year. The committee interviewed 13 students, and loans were granted to 11, for a total of $9,900.00. Of the 13 students interviewed, one asked that the loan be held in abeyance and another student received a loan from another source.

Under the Guaranteed Loan Plan with the Indiana National Bank, which was instituted December 1, 1963, the association has on deposit with the bank $20,810.00 to guarantee loans totaling $260,125.00. As of July 31, 1968, 81 loans, totaling $68,800.00, have been granted under this plan.

A report on the Loan Fund which was under association management from October, 1955, to December 31, 1963, follows:

Total loaned to 117 students . . $58,458.36
Total repaid by loances as of July 31, 1968 . . . . . 53,080.36
Total amount outstanding, July 31, 1968 . . . . . $ 5,378.00
Of the 117 who received loans—
99 have repaid in full
*18 are making payments ($5,378.00)
*Total due on above 18 loans still outstanding $5,378.00

The committee is making every effort, with the assistance of the attorney to collect these unpaid accounts, some of which are overdue.

LESTER D. BIBLER, M.D., *Chairman*
G. O. LARSON, M.D.
LESTER H. HOYT, M.D.
GLENN W. IRWIN, M.D.
DONALD R. TAYLOR, M.D.
JAMES O. RITCHEY, M.D.
ROBERT HOLLOWELL, *Attorney*

Future Planning Committee

The activities of the Future Planning Committee of the association this past year were minimal because of two factors: number one, there was no real problem posed for consideration by the group, and number two, many problems of a future planning nature are being currently undertaken by committees of the Council and the commissions of the Indiana State Medical Association.

For example, the Council, through its subcommittees, is presently giving serious study to problems involving emergency medical services, orientation of new members, membership matters and fiscal matters, to mention but a few.

Presently being planned is a survey of the membership by a Council committee, which when completed, may reveal some areas of study which should and could be properly projected by the Future Planning Committee during the forthcoming year.

EARL W. MERICLE, M.D., *Chairman*
MAURICE E. GLOCK, M.D.
JAMES S. FITZPATRICK, M.D.
A. WAYNE RATCLIFFE, M.D.
FRED S. CARTER, M.D.
WILLIAM B. CHALLMAN, M.D.
JAMES E. WENGER, M.D.
CHARLES F. GILLESPIE, M.D.
LESLIE M. BAKER, M.D.
PATRICK J. V. CORCORAN, M.D., *(ex-officio)*
G. O. LARSON, M.D. *(ex-officio)*
LOWELL H. STEEN, M.D., *(ex-officio)*
RALPH V. EVERLY, M.D. *(ex-officio)*
FRANK B. RAMSEY, M.D. *(ex-officio)*

Building Committee

The Building Committee has not met during the past year because no business has been referred to it.

The building is being kept in a good state of repair. The Pennsylvania Street properties have been paid for and this now makes the association debt free as far as its real estate holdings are concerned. The building now being six years old has necessitated a few minor repairs and the replacement of some working parts.

The building is seeing increased usage by medical groups and the committee, along with the approval of the Executive Committee, has approved the use of the building once a month during September, October, and November by the Indiana Chapter of the Student American Medical Association. We hope this will foster a closer relationship between the medical students and the association.

RALPH V. EVERLY, M.D.
Chairman
FREDERIC W. BROWN, M.D.
R. CASE HAMMOND, M.D.
JACK E. SHIELDS, M.D.

Reports of Commissions

Constitution and Bylaws

The report of the Commission on Constitution and Bylaws has been delayed. It will be presented in the Handbook.

Legislation

The Legislative Commission held its organizational meeting on November 5, 1967. The following officers were elected: chairman, Dr. Dwight W. Schuster; vice-chairman, Dr. Donald Wood; secretary, Dr. Jack Hickman.

The chairman attended a meeting of the AMA Council on Legislative Activities on January 20, 1968. The agenda, which with supporting reference material made a book of 155 pages, was on national legislative issues. This was a most informative and valuable meeting in the opinion of the chairman.

At the commission meeting on February 18, 1968, resolutions passed by the House of Delegates in October, 1967 pertaining to legislation were examined. Resolution #67 from Lake County was in regard to designation of regional tuberculosis hospitals and establishment of outpatient follow-up clinics. Opinion was sought from Dr. Offutt, State Health Commissioner. Dr. Offutt pointed out that such a program would involve extensive legislation which, in his opinion, was not necessary. He stated there is existing legislation which will permit counties to use excess beds for treatment of long-term care cases. Also, county hospitals may arrange intercounty cooperative agreements and clinics may be established by counties as needed without state mandate. Dr. Offutt further recommended comprehensive health planning be used to meet local tuberculosis problems.

Discussion was held relative to preparing a bill to enable the State Board of Medical Registration to maintain professional ethics, to increase registration fees and to retain fees collected for the use of the Board, especially to hire more investigators and to prosecute offenders of the Medical Practice Act. Question was raised regarding investigation of reported need for permitting selected foreign trained physicians to practice in state institutions without examination. Dr. Sheeley, Mental Health Commissioner, subsequently reported that his department and especially the hospital superintendents were not in favor of lowering the standards for physicians in the Department of Mental Health. Dr. Alcorn and the Commission on Medical Education and Licensure also discussed this matter, and Dr. Alcorn was to report to the ISMA Council. The Legislative Commission has not done anything further about these matters.

The chairman of the commission met with Mr. Albert Kelly, of the State Department of Welfare, and discussed possible legislation for Title 19 or Medicaid. Mr. Kelly indicated that a Legislative Advisory Committee was working on this matter. He was of the opinion that the bill to be proposed by the advisory group would be the same bill as introduced in 1967, other than for changes on income limits. Reduction of income eligibility limits was necessary due to changes in the Federal Law.

At a subsequent meeting of the commission, Dr. Charles Petty, a forensic pathologist, discussed proposed legislation in the area of forensic medicine and establishment of a Medical Examiner System. He agreed to review our bill of the 1967 session (HB 1739) and to send pertinent comments and suggestions about it by July 15, 1968.

Other items suggested for preparation of legislative action included (1) one defining blood as a service and not a sale, (2) a bill granting immunity for utilization review and hospital tissue committees as well as one granting immunity to school physicians and nurses, (3) a bill concerning disposition of human remains and parts thereof, (4) a bill for regulation of ambulances and attendants. Finally, a bill which was introduced in the 1967 session relative to treatment of venereal disease in minors without consent of parents was discussed and it was agreed this should be referred to the House of Delegates in October, 1968 for their decision.

At the beginning of the year it appeared that the Legislative Commission was going to get a running start on legislative matters and especially the preparation of possible bills through the able and cooperative services of Mr. Robert Robinson. However, changes in his relationship to ISMA occurred after our meeting on February 18, 1968, so that anticipated services were not available. Hence, the commission is in about the same condition as usual in the year prior to the meeting of the State Legislature. That is to say, the commission as reported above has numerous suggested bills which will require considerable legal work prior to January, 1969. It is anticipated that the commission will meet again September 15, 1968, in order to consider further legislative proposals and to make preparations to discuss legislative matters at the House of Delegates meeting in October, 1968.

As always, the commission is indebted to the office personnel of ISMA, the executive secretary, and his entire staff for helping to carry out the duties of the commission.

DWIGHT W. SCHUSTER, M.D., *Chairman*
DON E. WOOD, M.D., *Vice-Chairman*
JACK W. HICKMAN, M.D., *Secretary*
DANIEL M. HARE, M.D.
HAROLD MANIFOLD, M.D.
ELMER L. WALLACE, M.D.
LESLIE M. BAKER, M.D.
FRED W. DIERDORF, M.D.
JOHN DAVIS, M.D.
GUY A. OWSLEY, M.D.
MAX N. HOFFMAN, M.D.
DANIEL RAMKER, M.D.
LESTER RENBARGER, M.D.
EUGENE F. SENSENY, M.D.
OTIS R. BOWEN, M.D.

Public Information

The Commission on Public Information met twice during the 1967-1968 calendar year. The first meeting on November 5, 1967, was an organizational meeting at which officers were elected and tentative plans for programs to be accomplished during the year were initiated. The second meeting was held February 18, 1968, at which time the previously established programs were reviewed and several new programs were launched.

The following programs have comprised the activities of the Commission on Public Information during this year and their current status will be noted:

1. *Television Series, Blue Cross-Blue Shield.* The commission reviewed the plan of Blue Cross-Blue Shield to underwrite the cost of four television shows in Indiana during 1968. The commission came to the following conclusions on the shows: (1) That the Indiana State Medical Association should endorse the show along with the local medical society involved, the local TV station and Blue Cross-Blue Shield; (2) That societies should have the option to utilize local physicians in the live portions of the show or utilize the shows as presently filmed, using Marion County Society physicians; (3) Confirm that it would be good public relations for Blue Cross-Blue Shield to notify physicians of times and locations of the shows. The shows are tentatively being planned for television outlets in Indianapolis, Fort

Wayne, South Bend, Evansville and Terre Haute.

2. *Film "Horizons Unlimited".* The commission previewed this film which is designed to encourage young people to enter the health professions. They recommended that the county medical society officers be advised of the availability of this film through the AMA, because of the excellence of contents.

3. *Medical Self-Help Television Film Series.* The commission circulated to presidents and secretaries of the component county medical societies a memorandum advising them of the availability of these films for local use which were purchased by the Indiana State Medical Association in 1965 and have been little used. The commission also advised the State Civil Defense Director of the films' availability and urged cooperative programming in their use at the county level.

4. *Outdoor Billboards.* At the direction of the commission, Mr. Kenneth Bush met with representatives of some of the voluntary health agencies to discuss the possibility of a cooperative venture utilizing billboard space throughout the state to display health education messages. They emphasized the feeling that the budgets of their agencies would not stand the cost of such a venture at this time. As a result no current recommendation was made to the Council but the subject will be followed further to find a method of financing.

5. *Journalism Awards.* The commission circulated to presidents and secretaries of the county medical societies information and facts on the annual journalism awards program. At the time of this writing the commission has received a number of applications and will complete selection for the award prior to the annual convention in Fort Wayne, at which time the citations will be made.

6. *Booklet on ISMA Services.* The commission reviewed copy for this booklet, approved it and following approval of the Council, produced it. The booklet is now available for distribution and plans are to include it in the kit of materials for new members of the ISMA who participate in the "orientation course", and to distribute it to all members of the association. Thanks to the work of Mr. Kenneth Bush, the booklet has been an excellent production.

7. *Teacher Kit on Quackery.* This kit, produced by the AMA, upon review of the commission, was submitted to the office of the State Superintendent of Public Instruction, through the Indiana State Board of Health, for approval in distributing to school libraries. Once this approval is received the commission will go ahead with plans for distribution. The commission feels, however, that if the Department of Public Instruction does not approve the material, that the kit should be referred to the Council for their review before distribution is made.

8. *Miss Indiana Good Health Contest.* The commission explored the idea of selecting a "Miss Indiana Good Health" with the announcement of the selection made at the annual convention of the association. Purpose of the proposed selection would be to focus attention upon some particular health theme each year such as physical fitness, health careers, immunizations and others. The Council of ISMA reviewed this proposal at their March 8, 1968, meeting and voted disapproval of the project.

9. *Better Professional Cooperation with Allied Groups.* The commission recommended to the Council that "in the interest of improving professional relations with allied groups, that the Indiana State Medical Association invite to the annual convention each year the membership of the following organizations." The commission named several organizations. The Council, on May 19, 1968, approved in principle the idea of extending an invitation to paramedical and other ancillary groups and specifically named the groups at that time. These groups have now been invited to attend our annual meeting in Fort Wayne.

10. *Budget for Health Education Materials.* The commission requested a budget of $300.00 to meet requests for literature on health matters which come from teachers, students and others. This amount was approved by the Council.

11. *Project Concern, Incorporated.* The commission reviewed this project which deals with medical care in Vietnam and recommended that no action be taken on this project at this time because of the present fluid situation in Vietnam.

12. *County Society Officers' Meeting.* The commission recommended that the council re-establish an annual meeting for county society officers where they could discuss mutual problems to their own benefit. Such a conference was held this year (1968) on March 30 and 31 but dealt only with the subject of comprehensive health planning and the role of the county medical society and the individual physician in such planning.

13. *Preceptor Program Documentary Film.* The commission has encouraged the development of a film for television showing and for use by county medical societies and health careers public relations programs. Dr. George Lukemeyer, who has been assisting in the coordination of the preceptor program at Indiana University Medical School, has expressed interest in assisting in the development of such a film.

It is the hope of the commission that a professional film, emphasizing all aspects of the preceptor program, will be produced and so recommended to the Indiana State Association.

The above actions have comprised the work of the commission during the past year. This work is still continuing and will be passed on to the commission of next year.

FREDERIC L. SCHOEN, M.D., *Chairman*
WILLIAM B. CHALLMAN, M.D., *Vice-Chairman*
WILLIAM G. MOORE, M.D., *Secretary*
LOUIS H. BLESSINGER, M.D.
ROBERT D. SPINDLER, M.D.
ROBERT W. HARGER, M.D.
DON W. BOYER, M.D.
THOMAS C. CHAEL, M.D.
FRED C. POEHLER, M.D.
LOUIS F. SANDOCK, M.D.
LOREN H. MARTIN, M.D.

Governmental Medical Services

The commission has considered many matters during the past year and many of them have been discussed in other commissions of the medical association.

We have:

1. Supported pathologists plea for separate billing.
2. Recommended possibility of showing "Medical Self-Help" movie through TV stations in South Bend, Ft. Wayne and Evansville.
3. Reviewed unusual OCHAMPUS claims (old Medicare and Dependents Care.)
4. Spent considerable time on (A) Comprehensive Health Plan—(B) Medicaid Title 19.
5. Reviewed prison medical services at the state prison and also other institutions and at present are exploring possibility of legislation to aid medical services in the state prison and other establishments within the Department of Correc-

tion. (State prison at Michigan City has the only hospital, others have infirmaries. Indiana has the Indiana Regional Medical Program for Heart Disease, Cancer and Stroke. They have published a paper called "Link". Executive Committee for this program is functioning well.)

The Comprehensive Health Plan (Public Law 89-749) has an Advisory Committee of 65 persons. The Indiana State Board of Health is formulating a plan. Information to formulate this plan will be obtained as follows:

A. Groups are needed to tell what is needed at local levels. We must plan at local levels.

B. We need local planning groups (county and/or city).

C. Indiana State Board of Health will write the plan with all local help and advice that they can get.

JEROME E. HOLMAN, JR., M.D., *Chairman*
RAMON B. DUBOIS, M.D., *Secretary*
CHARLES HENDRIX, M.D.
GUY H. WALDO, M.D.
HERMAN ECHSNER, M.D.
DICK J. STEELE, M.D.
TOM S. SHIELDS, M.D.
ROBERT P. SCOTT, M.D.
J. F. HINCHMAN, M.D.
EDWARD J. DIEROLF, M.D.
DONALD K. WINTER, M.D.
GEORGE D. BUCKNER, M.D.
D. D. SWIHART, M.D.
GLEN V. RYAN, M.D.

Public Health

During the past year this commission, as with most of these groups, found the response to requests for assistance and participation in committee activities was limited to a small number of physicians appointed to the commission, although, at one time or another, nearly all have made some type of contribution. As in previous years, the biggest effort for the commission was the planning and presentation of Junior-Senior Day. Programming was altered from previous years to include a more current approach to the problem of encouraging junior medical students to intern and ultimately to practice in Indiana. The attendance was less than anticipated, but those present did express considerable interest in the presentations. Letters from communities which had representatives at this meeting indicated they had an opportunity to discuss their area with several of the students and asked that they be considered for future programs. Whether or not this particular function is to be continued must be decided by the Council as soon as possible. Tentative plans and reservations for next year's program have been made.

The matter of school health has received considerable attention, particularly in reference to requirements for tuberculin testing for children and a more aggressive case finding program among teachers. It was proposed by the commission that a Health Fair be held in conjunction with the 1969 meeting. This program is being developed and will have as a primary emphasis the development of communication between physicians and school administrators as regards school health policies and health education within each community. A member of the committee has been appointed to develop a preliminary plan for this program involving representatives from Indiana Health Careers, Inc. and the Indiana State Board of Health, Bureau of Health Education and the various health related organizations, including professional groups. This plan will be presented to the Council prior to the 1968 convention.

The efforts on traffic safety have been more in the nature of consultations and cooperation with other agencies. Chairman of the commission attended a meeting of the American Medical Association Committee on Medical Aspects of Automotive Safety. There was considerable exchange of information during the day and I became much more aware of the extent of this committee's involvement in automotive safety. I have been invited to attend a symposium on automotive safety in Washington, D.C. in September, and will represent the ISMA at that meeting. One piece of unfinished business in this context is the need for a driver improvement program and defensive driving course as developed by the National Safety Council. Stimulus for widespread use of this excellent program could well come from the state and county medical societies. A more definite program for utilization of the defensive driver course will be presented to the Council.

The area of industrial medicine did not receive much attention from this commission; although, I am sure, there are problems that should be brought to the commission for consideration. This is especially true with the present push for federally controlled safety standards. The commission members have been invited to participate in a program on industrial medicine at Crane Naval Depot in August.

In the area of environmental health, the ever recurrent problems of area sanitation and operation of the local health departments were given considerable airing. Members of this committee have participated in, and contributed to, the development of proposed legislative programs to strengthen the local health units. These, of course, are coming under the attention of the legislative commission and the actions of the Committee on Public Health will be primarily to support these bills in whatever way the Commission on Legislation feels most advantageous.

Similar programs are being considered in the area of preventive medicine. This commission seems quite concerned with the increasing incidence of venereal disease in adolescence and with the obviously inadequate statistical data resulting from physician negligence or procrastination in reporting those cases coming to their attention. The matter of tuberculosis control was also emphasized. Members of this commission participated in programs seeking to improve these control measures.

We have continued to have excellent relationships with the various departments of the State Board of Health. Members of this commission have assisted in the presentation of programs on infectious disease control within hospitals to various groups. This is a continuing program and deserves the fullest support of the ISMA. In turn, the attitude and procedures of the State Board of Health have made effective use of recommendations from this medical organization.

As usual, when one prepares this type of report, there is much more to be done than has seemingly been accomplished.

It is proposed that emphasis be put in the coming year on three major areas:

(1) The development of a broader base in communication between physicians and educators and enhancement of the health education programs;

(2) A re-evaluation of the status of industrial medicine and of its purpose, especially as these effect the relationships between the private physicians and the industrial medical departments, and;

(3) More active participation by physicians and organized medicine in local and statewide traffic safety programs.

T. O. MIDDLETON, M.D., *Chairman*
HENRY G. NESTER, M.D., *Secretary*
DANIEL HARE, M.D.
ROY L. FULTZ, M.D.

R. M. SEIBEL, M.D.
CLEON M. SCHAUWECKER, M.D.
WILSON L. DALTON, M.D.
STANLEY W. BURWELL, M.D.
THEODORE C. PERSON, M.D.
GILBERT Z. GIVEN, M.D.
PAUL SPARKS, M.D.
BERTRAM ROTH, M.D.

Voluntary Health Agencies

The commission met for its organizational meeting at the Indianapolis Athletic Club on Sunday, November 5. The officer's elected were Dr. M. O. Scamahorn, secretary; Dr. James Gosman, vice chairman; Dr. Norman Booher, chairman.

The organization meeting was taken advantage of by a long business meeting following. Future meetings of the commission were set and reported to the headquarters office. The action of the House of Delegates on the 1966-1967 report was studied and assignments of liaison representatives to all of the voluntary health agencies with a statewide program were made.

Plans were made for the activities of the commission for the entire year and it was planned to have a meeting of all of the voluntary health executive officers, including presidents and executive secretaries, together with the commission in January. The Medicine and Voluntary Health Day was planned in conjunction with the annual meeting of the Indiana Public Health Association for Wednesday, May 1. At the very first meeting, it was felt that it was imperative that the poster of recognized agencies be distributed as widely as possible.

A new program was suggested by some of the younger members of the commission and that was that the voluntary health agency programs should be made known to the medical students.

The commission also made the suggestion to the officers of the ISMA that the voluntary health agencies constituted a superb resource for top scientific speakers in the programs of the ISMA.

On January 28, the members of the commission met in the Board Room of ISMA with the presidents and executives of all of the voluntary health agencies having statewide programs in Indiana. At this meeting the floor was open for criticisms and suggestions.

The great preponderance of discussion was very favorable to the image of the ISMA and nearly every agency expressed their deep appreciation for the involvement of organized medicine in the voluntary health program. The commission felt that the public relations impact of this meeting was tremendous. In addition, it was agreed between the voluntary agencies and the commission that another cooperative scientific program would be presented on May 1 at the annual meeting of the Indiana Public Health Association.

The joint Committee of Voluntary Agencies and the commission was formed to plan for a meeting with the medical students of the Indiana University School of Medicine on March 27, 1968. Each agency was given the opportunity to make a three minute oral presentation, giving the highlights of the program of their agency and each agency was allowed to include one pertinent piece of literature on their agency in a file folder printed for this purpose by the ISMA. In spite of the excellent cooperation of the deans of the school of medicine, this program was made voluntary on the part of the students and a poor attendance resulted. In spite of the poor attendance, however, each of the agencies made its presentation and the folders were distributed. It was felt by the commission that in spite of the poor attendance this was an important new project which can be extended in future years.

The scientific presentation mentioned above in connection with the annual meeting of the IPHA was held on May 1 at the Howard Johnson's Motor Lodge, Indianapolis. Three well known speakers were presented, including Dr. Robert L. Yeager, President of the American Thoracic Society; Dr. Brewster S. Miller, Medical Director of United Cerebral Palsy and Dr. Frank Lloyd, Director of Medical Research, Methodist Hospital, Indianapolis. Attendance at this meeting was excellent and reaction was very good. The folders left over from the March 27 meeting were made available at this meeting and, therefore, utilized.

Following the scientific meeting on May 1, the commission met in the afternoon for its final meeting of the year and the program for the year was reviewed. It was decided that a similar program should be proposed to the commission next year, including the medical school effort and some ideas for this program were brought out.

At the scientific meeting on May 1 and at the commission meeting, the commission was privileged to have as a guest, Mrs. Barbara Farley Main, Executive Officer of the Council on Voluntary Health Agencies of the American Medical Association.

Throughout the entire year, the commission received rumors and hearsay information that the programs of the commission were in question in the Council of ISMA. No official communication of this ever reached the commission. However, the chairman of the commission was called before the Council on May 19, at which time he reviewed the history of the commission and its work in detail and called the attention of the Council to the fact that on February 8, a complete report had been made to the chairman of the Council on the activities of the commission, including publication and distribution of the placards, publicizing the recognized voluntary health agencies in this state. It was pointed out that the action of the House of Delegates at the last meeting was that the program of this commission had been not only approved but recommended that it be continued. The question raised by the Council seemed to be the matter of expense in distributing the placards of the organizations recognized. Finally, the commission was instructed to publish the placard in a similar manner as last year and to distribute these in bulk to the voluntary agencies, that every physician member of the ISMA would receive one of these placards for his office by the field men of the association taking adequate quantities to each county, together with a proper explanation of the work being done and they would distribute these to the county medical societies. The demand on the part of the voluntary health agencies for these placards has exceeded any previous year, and in fact these placards are even being used as presentation pieces by some of these agencies.

We have had some correspondence from county medical societies concerning local agencies and we have reiterated the position of the commission that we can deal only with agencies having statewide programs and we again hope that every county society will establish a committee to deal with local agencies not having a state organization.

Attendance at the commission meetings by some of the members continues to be a problem. During the three regular meetings of the commission held this year, the Sixth, Seventh, Eighth and Tenth Districts failed to have a representative at any meeting; the Second, Third, Fourth and Eleventh Districts had a representative at but one meeting; the Ninth and Twelfth Districts were represented at two meetings and the First and Fifth Districts and the three members-at-large attended all meetings.

The commission recommends that the program be continued in a similar vein because it is felt that the public relations impact of this program has been very high and that its value could not be pur-

chased with any calculable sum. It was also felt that the entire association should endeavor to assist this commission in giving widespread publicity to its programs and efforts and especially to the agencies who meet the difficult criteria laid down by this commission.

This chairman deeply appreciates the dedication of the several men who carried the work of the commission during the year, and is especially grateful to Doctor Scamahorn and Doctor Gosman, and the other officers of the commission for their encouragement, work and support.

The entire commission wants to publicly express its enthusiastic thanks to Mr. Kenneth Bush of the staff and to Miss Eleanor Chapple, who has finished yet another year as a very faithful secretary.

NORMAN R. BOOHER, M.D.
Chairman
JAMES H. GOSMAN, M.D.
Vice-Chairman
M. O. SCAMAHORN, M.D.,
Secretary
ALBERT RITZ, M.D.
ED R. CANTWELL, M.D.
T. A. NEATHAMER, M.D.
HARRY R. BAXTER, M.D.
WILLIAM G. BANNON, M.D.
WAYNE ENDICOTT, M.D.
WILLIAM A. KARSELL, M.D.
JAMES S. FITZPATRICK, M.D.
ALBERT E. APPLEGATE, M.D.
JOHN G. KOLETTIS, M.D.
LLOYD L. HILL, M.D.
RICHARD WILLARD, M.D.
FRANK J. MCGUE, M.D.

Inter-Professional Relations

The Commission on Inter-Professional Relations has had two meetings scheduled and both had to be cancelled due to lack of members intending to attend.

FRED FLORA, M.D.,
Chairman
VIRGIL E. ANGEL, M.D.,
Vice-Chairman
WM. S. ROBERTSON, M.D.,
Secretary
A. WAYNE RATCLIFFE, M.D.
PHILIP R. KARSELL, M.D.
CHARLES X. McCALLA, M.D.
JOHN W. RIPLEY, M.D.
RICHARD L. VEACH, M.D.
WILLIS W. STOGSDILL, M.D.
H. H. DUNHAM, M.D.
PIERRE C. TALBERT, M.D.
A. ALAN FISCHER, M.D.
ROBERT G. HUSTED, M.D.

Medical Education and Licensure

During this year the commission has met five times (September and November, 1967, January, March and May, 1968) and done a significant amount of work. Our activities have been in five fields: Postgraduate Education; Preceptorships; the Doctor Shortage; Licensing; and two recommendations to the Council.

1. *Postgraduate Education*: In nearly every meeting the great variety of postgraduate medical education available in the state was bought up. Dr. George Lukemeyer, of the Indiana University Medical Center, kept the commission informed on the progress of the many programs sponsored by the medical center. These involved not only the well-established activities such as supplying local medical societies with speakers for their meetings; supply of reprints on any subject on request from the library at the medical school; (TWX connections for rapid service are available in many locations through local librarians) and two way telephone hook-ups which are used by seven hospitals across the state, but also a variety of new techniques of postgraduate education.

Seventeen videotape machines have been placed about the state in hospitals and clinics. These will use existing educational videotapes on medical subjects put out by drug companies and medical schools, as well as new tapes being produced at Indiana University Medical Center. They will be connected to Indiana University Medical Center for live programs and selected hospitals will produce their own tapes locally.

Visiting faculty arrangements have been made between at least two cities and Indiana University Medical Center—Evansville and Lafayette.

Special clinics are held in a number of cities in the state: Epilepsy Clinics at Terre Haute and South Bend; a Cardiac Clinic at South Bend; a Tumor Clinic at South Bend and one for crippled children at Richmond.

Discussion was held on the subject of requiring doctors to keep up their postgraduate education in various ways. It was felt that membership in ISMA should not be contingent on evidence of continued education but that it might be worth forming an academy within ISMA, membership in which would be contingent on continuing education. Whether relicensing of doctors might be made dependent on the physician taking a minimum amount of postgraduate education is the decision of the State Board of Licensure. Precedents for such requirements for postgraduate education are the American Academy of General Practice and the Oregon Medical Society.

With the agreement of the commission, Dr. Lukemeyer sent out a questionnaire on postgraduate education to all ISMA physicians—a big job, the results of which are now being tabulated.

II. *The Preceptorship Program*: This is an ongoing program in its third year and during this school year (1967-68) involved approximately 20% of the senior class. A successful drive for new preceptors was conducted. The commission reconfirmed its conviction that the program (1) should not include preceptors in Marion County, and; (2) it should continue to be a voluntary, not compulsory, part of the students' experience.

It was decided that five years are necessary before an evaluation of the achievements of the preceptorship program could be made.

The commission is grateful for the cooperation of all the physicians of the state who have been willing to be preceptors and, thus, make the program a success.

III. *The Doctor Shortage*: The physician shortage in Indiana was discussed in several meetings. The medical school trains proportionately more doctors in relationship to our population than most neighboring states; yet we do not keep them here to practice. Their staying here is chiefly dependent on (1) Indiana's developing competitive (with the rest of the nation) internship and residency programs. This is recognized and is being corrected gradually. (2) Activities of local communities in attracting doctors. The commission appointed a committee to investigate how ISMA might aid communities to obtain doctors. A news release was thought important to help local communities realize *their* important role. The ISMA office also has very good pamphlets for communities who need to find doctors such as "A Doctor for Your Community" and they will cooperate in every way with communities who contact them for such help.

IV. *Licensing*: The area of licensing occupied much of the commission's time. Dr. Alcorn, president of the State Board of Licensing, brought us information and requested our help on a number of problems.

Seventy percent of 138 foreign medical graduates took the state board examinations in June, 1967, and of these, 70% passed. Of the 70%, 15% remained in Indiana to practice. These statistics say 1). Indiana's essay exam is easier to pass than the National Board type so we attracted a relatively large number of foreign graduates to our examination; 2). Many foreign graduates took our exam for the

purpose of getting a license in another state by reciprocity.

By considerable effort and cooperation of many persons and institutions, it almost occurred that the objective, machine-graded exam of the Federal State Boards was given in June, 1968, but Governor Branigin felt that extra needed money from the state could not be used without legislative approval. However, the commission voted that such an exam should be used as soon as it could be managed. Such an exam is within the Indiana law.

The subject of a special limited license for institutional physicians was discussed on two different occasions and it was the considered opinion of the commission that this was not a wise step, even though some of our institutions feel the need greatly, and we did not recommend it.

V. *Council Recommendations*: The Council referred to the commission a request for endorsement from Ivy Tech and arranged a hearing at which A. P. Coffin and James M. Leffel, M.D. of Ivy Tech told about their schools. After much discussion it was the unanimous opinion of the commission that it recommend to the Council endorsement of Ivy Tech by ISMA.

Also a hearing was held for a problem the podiatrists have. Indiana attorney general's opinions of 1943 and 1953 have specifically intoned against the use of antibiotics and narcotics in the treatment of diseases of the feet by podiatrists. However, the podiatrists point out all schools of podiatry in the nation are Class A and give extensive and adequate instruction in the use of such drugs; 2) It is necessary to use these drugs for the proper practice of podiatry and in fact almost all presently practicing podiatrists do use them; 3) New podiatrists are kept out of the state by the attorney general's ruling, and the state is in real need of more podiatrists; 4) The great majority of the states in the nation permit podiatrists unlimited use of medications (13 only make limitations) in treating diseases of the feet.

Therefore, the commission recommended to the Council of ISMA that ISMA go on record permitting the use of systemic medications by podiatrists for foot disease.

For the year ahead, in addition to the usual ongoing activities of the commission, there is one job and one policy position that need attention. The job is to conduct a survey of medical and paramedical manpower needs for the purpose of Comprehensive Health Planning. The policy position concerns the development of physician assistants, a possible way of relieving the physician shortage.

The chairman wishes to thank the members for their good attendance at considerable personal sacrifice, and their willingness to work and deal conscientiously with a wide variety of subjects in their field.

JAMES B. JOHNSON, M.D., *Chairman*
JOHN L. CULLISON, M.D., *Vice-Chairman*
FORREST LaFOLLETTE, M.D., *Secretary*
BETTY DUKES, M.D.
JOHN M. PARIS, M.D.
RICHARD A. SNAPP, M.D.
FRANK COBLE, M.D.
WILLIAM RINGER, M.D.
LEO RADIGAN, M.D.
LOWELL J. HILLIS, M.D.
JOEL SALON, M.D.
JENE R. BENNETT, M.D.
MERRITT O. ALCORN, M.D.
PETER J. PILECKI, M.D.
GLENN W. IRWIN, JR., M.D.
KENNETH SHERER, M.D.
GEORGE T. LUKEMEYER, M.D.

Special Activities

The Special Activities Commission met three times during 1967-1968. Work concerning the blood banks was nearly completed. In the future a series of articles is planned for publication in *The Indiana State Medical Journal* concerning the use of blood and the component parts of blood. Also, at the state meeting in Fort Wayne in October, there are scientific exhibits expected concerning blood banks. The exhibits will acquaint ISMA members with the functions of blood banks in Indiana, their make-up, their sponsors and other pertinent information about blood uses and blood banks.

President Larson requested the commission to make a detailed study of the American Medical Association Education and Research Foundation to determine if it deserves our continued support, and if so, whether we should try to increase this support. Dr. Marvin Priddy spent two informative days in Chicago with the Education and Research Foundation of AMA. His detailed report was presented at the January Special Activities Commission meeting. After study of the information, the commission recommended the continued and increased support of AMA-ERF. A more detailed report can be found in the May issue of the state *Journal*, page 594.

The Special Activities Commission pledged further assistance to the Council in implementing the orientation program for new members of the state medical association. The commission and its members will help in any way possible with this program.

The study of medicine and its interrelationship with religion was planned. It is hoped further study of the interdependence of clergy and medicine will be undertaken in the future. The commission members hope to meet with the AMA chaplain at the state meeting in October and plan some studies relative to both professions.

MARVIN E. PRIDDY, M.D., *Chairman*
ROBERT M. BROWN, M.D., *Vice-Chairman*
RAY H. BURNIKEL, M.D.
NORBERT M. WELCH, M.D.
ROBERT O. ZINK, M.D.
JOHN E. FREED, JR., M.D.
HAROLD C. OCHSNER, M.D.
HENRY BIBLER, M.D.
CLARENCE G. KERN, M.D.
ADOLPH WALKER, M.D.
K. G. HILL, M.D.

Aging

The Commission on Aging met four times during the year. The first meeting was held on November 5, 1967. At this meeting the following officers were elected:

Chairman: George M. Young, M.D.

Vice-Chairman: A. W. Cavins, M. D.

Secretary: Raymond Duncan, M.D.

We reaffirmed our stand on independent living and our goals of developing measures to make independent living more available to the senior citizens of this state. Our budget for the year was set at $500.00 for travel and food and $200.00 for projects. Dr. G. O. Larson, our state president, requested that this commission work on a plan to simplify and expedite the enrollment of applicants and eligible recipients of Medicare. In order to accomplish this it was proposed that the state Social Security Office and the Blue Cross-Blue Shield have representatives at our next meeting.

The second meeting of the commission was held on February 4, 1968. Mr. Fred Wolf, Regional Representative from the Social Security Administration and Mr. Herbert Dixon of Blue Cross-Blue Shield met with us. Concerning the simplification of Medicare, Dr. A. W. Cavins made a motion that Blue Cross-Blue Shield send simplified, cartoon style instructions to Medicare recipients so that they can understand more easily the connection between their supplemental Blue Shield and their Medicare. The motion passed. It was suggested that the Independent Insurance Agents Association of Indiana and any

similar organizations be contacted for whatever help they might give. A motion was made by Dr. W. R. Van Den Bosch and later revised to this wording, "I move that this commission approve the policy that the Indiana State Medical Association assume no responsibility for public education on matters pertaining to contractual agreements, mechanisms and benefits of Medicare or other insurance programs; but encourage all members and member societies to cooperate in education programs according to their individual desire." The motion was approved.

A film, "The Home Health Aid" was shown to the commission. All members thought it was good, but decided to review other films of this type before recommending the purchase of such a film by the Indiana State Medical Association for its library to be used in organizing home health aid programs in local communities and by county societies. The one seen is available from the Indiana State Board of Health on a limited basis. General consideration of home health aid programs was taken up but no definite program was adopted.

At the third meeting of the commission, held on April 28, 1968, we took up the revising and updating of the Statement of Organized Home Care for the Sick and the Disabled which was first prepared by the commission in 1962. This statement needs to be updated to include Medicare and other measures which have come into being since that date. Dr. A. C. Offutt, Dr. W. C. Anderson and Dr. Robert Yoho were appointed as a committee to meet with Elizabeth Jones, Health Education Consultant of the Indiana State Board of Health, who requested that the commission help with the revision of this statement. Dr. Van Den Bosch encouraged the commission, as one of its objectives, through the Indiana State Medical Association, to put out some information to those people retiring or planning to retire at an early age. This is to prevent, if possible, some of the problems found in some of these people after retirement. This was called by Dr. Van Den Bosch "Preventive Geriatrics."

The commission held its fourth meeting on June 2, 1968. We discussed the policy statement of Organized Health Care for the Sick and Disabled. The commission went over the changes made by Dr. Wendell Anderson and his committee, and discussed them very thoroughly, making several other revisions, and requested that the commission's recommendations be added to the policy statement and submitted to the Council for approval. After approval, the commission suggested publishing it in *The Journal of the Indiana State Medical Association*, in *The Bulletin of the Indiana State Board of Health*, and printing it in pamphlet form for circulation to organizations and individuals who request it. It was also suggested that the policy statement be sent to the Indiana Advisory Committee on Comprehensive Health Planning and to the Regional Medical Planning group for information and possible program incorporation.

The commission also discussed further Dr. Van Den Bosch's proposal that it incorporate in its objectives his idea of "Preventive Geriatrics" to compile information and suggestions for people who retire at an early age or who are nearing retirement age. It was suggested that we leave this as a project for the 1969 commission.

GEORGE M. YOUNG, M.D.,
Chairman
A. W. CAVINS, M.D.,
Vice-Chairman
RAYMOND DUNCAN, M.D.,
Secretary
BERNARD B. ROSENBLATT, M.D.
R. E. BUCKINGHAM, M.D.
WALTER S. FISHER, M.D.
GLEN A. RAMSDELL, M.D.
JOHN O. BUTLER, M.D.
WALLACE R. VAN DEN BOSCH, M.D.
GEORGE W. WAGONER, M.D.
NATHAN SALON, M.D.
DONALD T. OLSON, M.D.
ANDREW C. OFFUTT, M.D.
WENDELL C. ANDERSON, M.D.

Resolutions

Amendments to the Constitution to be Voted on at Fort Wayne Session, 1968

At the 1967 annual convention at Indianapolis, the House of Delegates adopted the report of the Reference Committee on Amendments to the Constitution and Bylaws, in which the Reference Committee recommended for adoption the following amendments to the Constitution:

Amend Article VI, of the Constitution as follows:

ARTICLE VI—BOARD OF TRUSTEES:

"The Board of Trustees shall consist of (1) the Trustees with power to vote and their duly elected alternates, each of the latter without power to vote except in the absence of his Trustee; and (2) ex-officio, the President, President-elect, Treasurer with power to vote and Assistant Treasurer without power to vote except in case the Treasurer be absent. Besides its duties mentioned in the Bylaws, the Board of Trustees shall have full charge and control of all the property of the Association."

The balance of the Article to remain unchanged.

Be it further resolved that the following amendments be made to the remainder of the Constitution:

(1) Substitute the words "Board of Trustees" in lieu of the word "Council" wherever said word appears therein. (2) Substitute the word "Trustees" in lieu of the word "Councilors" wherever said word appears therein. (3) Substitute the word "Trustee" in lieu of the word "Councilor" wherever said word appears therein.

Resolution No. 68-1

Introduced by: ELKHART COUNTY MEDICAL ASSOCIATION

Subject: MEDICAL LICENSURE

WHEREAS, the State Board of Medical Registration and Examination of Indiana gives only one yearly examination each June, and,

WHEREAS, applications must be completed and received by the first day of May, and grading is not complete before mid-September; (thus, a mid-May applicant would have to languish for 6 months prior to gaining licensure even if successful), and,

WHEREAS, Indiana physicians recognize a statewide physician shortage that is dangerously severe in some areas and abhor such discourteous inhospitality to needed and well qualified physicians,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association strongly convey to the State Board of Medical Registration and Examination dissatisfaction with the present situation, and further, that the Indiana State Medical Association do everything in its power to change this archaic process.

Resolution No. 68-2

Introduced by: LAPORTE COUNTY MEDICAL SOCIETY, INC.

Subject: RESOLUTION ADOPTED BY THE LAPORTE COUNTY MEDICAL SOCIETY, JULY 2, 1968 CONCERNING THE ESTABLISHMENT OF MEDICAL DEPARTMENT WITHIN THE STATE BOARD OF CORRECTION

WHEREAS, the State Board of Correction of the state of Indiana has within its jurisdiction the health of approximately 7,500 inmates, and,

WHEREAS, the operation of the medical department of these institutions has shown certain deficiencies in selection of medical personnel and procurement of medical supplies and equipment,

NOW, THEREFORE, BE IT RESOLVED, by the LaPorte County Medical Society, that the needs of inmates of the institutions of the State Board of Correction of Indiana would be better met by the establishment of a medical department under the direction of a licensed physician within the State Board of Correction, such department having authority for the selection and direction of personnel, procurement of medical supplies and equipment, and,

BE IT FURTHER RESOLVED, that this resolution be formally transmitted to the Indiana State Medical Association for consideration by the House of Delegates at the next session.

Resolution No. 68-3

Introduced by: THE FORT WAYNE (ALLEN COUNTY) MEDICAL SOCIETY

Subject: OCHAMPUS

WHEREAS, OCHAMPUS, since its inception in 1956, has been under the supervision and administration of the Indiana State Medical Association, and,

WHEREAS, the Indiana State Medical Association has struggled valiantly through governmental red tape and regulations to serve the dependents of servicemen, as well as the physicians of the state of Indiana, and,

WHEREAS, despite these efforts on the part of the Indiana State Medical Association, the physicians and patient participants throughout the state of Indiana find the administrative services to be inadequate,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association request Blue Shield to assume the administration of this program.

Resolution No. 68-4

Introduced by: THE FORT WAYNE (ALLEN COUNTY) MEDICAL SOCIETY

Subject: COVERAGE DURING PHYSICIAN ABSENCE

WHEREAS, many physicians are serving medicine and people by going out of the country to serve on medical missions,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association set up a committee to accumulate information about these missions and furnish information to members about these missions, and,

BE IT FURTHER RESOLVED, that this committee have district subcommittees to arrange for physician coverage while away and speaking engagements as desired when back, and,

BE IT FURTHER RESOLVED, that the Indiana State Medical Association committee establish liaison with the appropriate American Medical Association committee.

Resolution No. 68-5

Introduced by: LAKE COUNTY MEDICAL SOCIETY

Subject: FORENSIC MEDICINE

WHEREAS, problems in the field of forensic medicine are becoming of increasing interest and concern to the medical profession, and,

WHEREAS, the present Section on Pathology does not include a number of physicians serving as coroners, deputy coroners, etc.,

NOW, THEREFORE, BE IT RESOLVED, that Chapter 3, Sec. 1, item "J" of the Bylaws be amended to read as follows: "J. Pathology and Forensic Medicine" so as to include in its activities those physicians now interested or engaged in this field of medicine.

Resolution No. 68-6

Introduced by: THE FORT WAYNE (ALLEN COUNTY) MEDICAL SOCIETY

Subject: DRIVER LICENSING

WHEREAS, the accident rate, per mile

driven, for 16 to 18-year-old licensed operators of motor vehicles on the public highways of Indiana is far in excess of the rate for any other age category, resulting in great loss of life among these operators, their passengers, and many innocents traveling upon the streets and highways, as well as property damage in prodigious amounts, astronomical insurance payments, and high insurance rates, only partially compensated by the special increased rates for these drivers, and,

WHEREAS, all physicians are fully aware that the judgment ability of persons 16-18 years old is much less mature than of persons more than 18 years old, and,

WHEREAS, state and local police officials consider the 16 to 18-year-old driver an especial hazard on the highway, and,

WHEREAS, the experience in states where the minimum legal driving age is 18 years has been most favorable in the reduction of injury and loss of life and property to the driver and innocent passerby alike,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association, as part of its function in the protection of public health and safety, recommend to the legislature of the state of Indiana that the legal age at which a motor vehicle operator may be licensed be raised from 16 years and one month to 18 years and one month, and,

BE IT FURTHER RESOLVED, that the Indiana State Medical Association shall seek the active support of the Indiana State Police and the Indiana Chamber of Commerce in proposing such legislation.

Resolution No. 68-7

Introduced by: BOONE COUNTY MEDICAL SOCIETY

Subject: SCHOOL ATHLETIC PROGRAMS

WHEREAS, the Boone County Medical Society is materially interested in the health and well-being of high school athletes, and,

WHEREAS, the Indiana High School Tournaments require high school basketball players to participate on some occasions in more than one basketball game per day, and,

WHEREAS, the Boone County Medical Society is convinced that more than one basketball game per day by a high school student places excessive physical strain on athletes in the high school age group, and,

WHEREAS, there have been numerous cases of leg cramps and undue physical strain on high school athletes as a result of participating in more than one high school basketball game per day, and,

WHEREAS, college and professional basketball teams restrict their activity to one game per day,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association petition the Indiana High School Athletic Association to limit basketball tournaments so as to permit high school athletes to participate in only one basketball game per day.

Resolution No. 68-8

Introduced by: THE MARION COUNTY MEDICAL SOCIETY

Subject: CREATION OF A NEW MEMBERSHIP CLASSIFICATION

WHEREAS, an increasing number of physicians, who have been members of the Indiana State Medical Association for 20 years or more, are retiring from active medical practice before they reach the age of eligibility for Senior Membership in the association, and,

WHEREAS, for such physicians the requirement that they continue to pay the full annual dues of their county medical societies, the Indiana State Medical Association and the American Medical Association until the year after they reach the age of 70 discriminates against them solely on the basis of age,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association create a separate membership category for such physicians, as long as they do not engage in active practice, with a reduction, at least, in the amount of annual dues they shall pay.

Resolution No. 68-9

Introduced by: THE MARION COUNTY MEDICAL SOCIETY

Subject: A BILL TO MAKE MINORS COMPETENT TO CONSENT TO, AND CONTRACT FOR, TREATMENT FOR VENEREAL DISEASE

WHEREAS, many persons under 21 years of age are reluctant to seek treatment for venereal disease for fear parents or guardians will be notified, and,

WHEREAS, physicians presently are in an untenable legal position if they treat a minor without the consent of his parent or guardian, and,

WHEREAS, treatment is urgent and barriers to it in the path of physicians and minor patients should be removed,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association arrange for introduction, in the 1969 Indiana General Assembly, of a bill which would make all persons under 21 years old competent to consent to, and contract for, treatment and/or hospitalization for venereal disease.

Resolution No. 68-10

Introduced by: THE MARION COUNTY MEDICAL SOCIETY

Subject: REVISION OF COUNCILOR DISTRICTS OF THE INDIANA STATE MEDICAL ASSOCIATION

WHEREAS, control of the Indiana State Medical Association by its membership, through elected representatives, can be assured only if those representatives are chosen on an equitable numerical basis, and,

WHEREAS, the Council of the association is its governing body between sessions of the House of Delegates, and,

WHEREAS, there continues to be inequity in representation on the Council of the association membership because councilors are elected from districts established on a geographical basis and not a numerical basis, and,

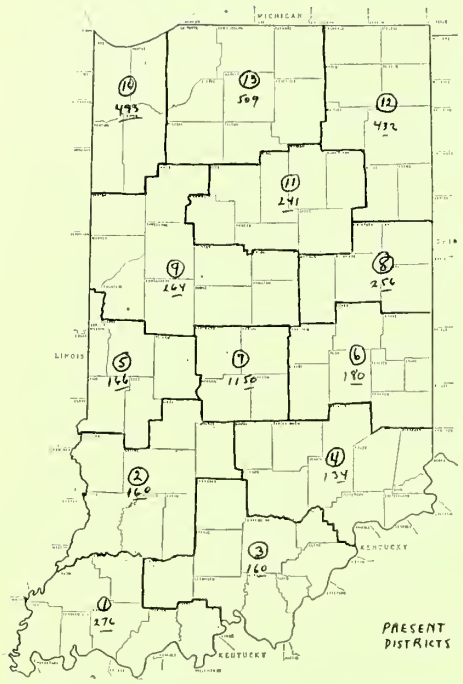
WHEREAS, as present districts are defined, one councilor represents as few as 134 members and another as many as 1,150 members, as indicated in the membership report of the association as of Dec. 31, 1967, yet each has an equal vote, and,

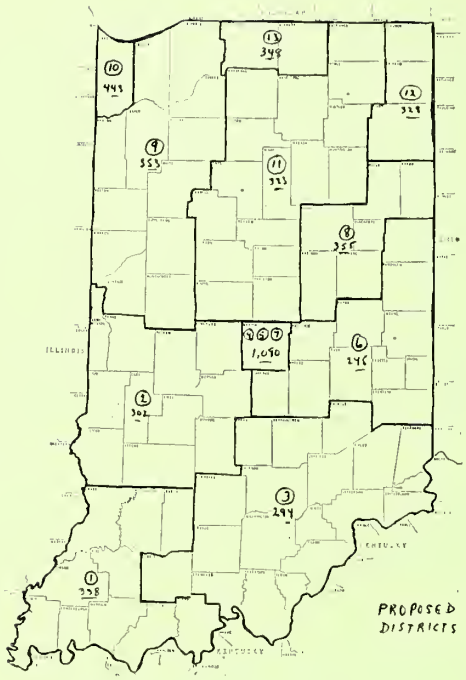
WHEREAS, seven of the 13 councilors represent a total of 1,297 members and the other six represent a total of 3,124 members, again revealing inequity of representation, and,

WHEREAS, this inequity of representation also is reflected in the composition of the various commissions of the association and on the Blue Shield Board of Directors, whose members, except for the members-at-large, are chosen by the councilor districts, and,

WHEREAS, the Constitution and Bylaws of the association provide that there shall be 13 councilor districts but leaves definition of the districts to the House of Delegates,

NOW, THEREFORE, BE IT RESOLVED, that the House of Delegates of the Indiana State Medical Association redefine the councilor districts on a numerical basis so that each councilor represents ap-





proximately 325 members of the association, and,

BE IT FURTHER RESOLVED, that in any county in which the medical society has a large membership, approximately 325 members shall constitute a district, and one group of officers and one councilor for approximately 325 members, shall be elected to serve the district, and,

BE IT FURTHER RESOLVED, that the 13 councilor districts shall be redefined as follows:

1st District	
Posey	8
Vanderburgh	233
Warrick	7
Spencer	4
Perry	8
Gibson	13
Pike	3
Knox	41
Daviess-Martin	21
Total Members	338

2nd District	
Parke-Vermillion	22
Putnam	16
Vigo	114
Clay	14
Sullivan	11
Greene	13
Owen-Monroe	72
Hendricks	20
Morgan	20
Total Members	302

3rd District	
Dubois	23
Lawrence	25
Orange	9
Harrison-Crawford	11
Floyd	39
Clark	41
Scott	5
Washington	7
Jackson-Jennings	25
Bartholomew-Brown	51
Decatur	9
Jefferson-Switzerland	23
Dearborn-Ohio	18
Ripley	8
Total Members	294

4th District

5th District

7th District	
Marion	1,080

6th District	
Johnson	30
Shelby	19
Hancock	22
Rush	15
Fayette-Franklin	16
Jay	16
Randolph	19
Henry	38
Wayne-Union	70
Total Members	245

8th District	
Madison	102
Delaware-Blackford	119
Grant	72
Wells	47
Adams	15
Total Members	355

9th District	
Porter	43
Starke	6
Jasper	7
Newton	5
White	10
LaPorte	98
Pulaski	5
Benton	8
Fountain-Warren	14
Tippecanoe	134
Montgomery	23
Total Members	353

10th District	
Lake	443

11th District	
LaGrange	9
Huntington	21
Marshall	25
Carroll	8
Clinton	20
Noble	16
Wabash	27
Fulton	10
Miami	11
Boone	21
Hamilton	18
Whitley	17
Kosciusko	17
Cass	32
Howard	70
Tipton	11
Total Members	333

12th District	
Allen	292
DeKalb	23
Steuben	13
Total Members	328

13th District	
St. Joseph	235
Elkhart	113
Total Members	348

BE IT FURTHER RESOLVED, that implementation of redistricting the association shall be accomplished as follows:

1*st District*. The councilor-elect shall serve until his term of office expires in Oct., 1971. Before expiration of his term of office, the newly defined district shall elect a councilor to succeed him.

The alternate councilor shall serve until his term of office expires in Oct., 1970. Before expiration of this term of office, the newly defined district shall elect an alternate councilor to succeed him.

2*nd District*. The present councilor shall serve until his term of office expires in Oct., 1969. Before the expiration of his term of office, the newly defined district shall elect his successor.

The alternate councilor-elect shall serve until her term of office expires in Oct., 1971. Before expiration of her term of office, the newly defined district shall elect her successor.

3*rd District*. The present councilor shall serve until his term of office expires in Oct., 1970. Before expiration of his term of office, the newly established district shall elect his successor.

The alternate councilor-elect shall serve until his term of office expires in Oct., 1971. Before expiration of his term of office, the newly established district shall elect his successor.

4*th District*. The councilor-elect shall serve until his term of office expires in Oct., 1971. Before expiration of his term of office, the newly established 4th, 5th and 7th districts shall elect his successor.

5*th District*. The present councilor shall serve until his term of office expires in Oct., 1969. Before expiration of his term of office, the newly established 4th, 5th and 7th districts shall elect his successor.

7*th District*. The councilor-elect shall serve until his term of office expires in Oct., 1971. Before expiration of his term of office, the newly established 4th, 5th and 7th districts shall elect his successor.

The present alternate councilor shall serve until his term of office expires in Oct., 1969. Before the expiration of his term of office, the newly established 4th, 5th and 7th districts shall elect his successor.

6*th District*. The present councilor shall serve until his term of office expires in Oct., 1970. Before the expiration of his term of office, the newly established district shall elect his successor.

8*th District*. The present councilor shall serve until his term of office expires in Oct., 1969. Before the expiration of his term of office, the newly established district shall elect his successor.

The present alternate councilor shall serve until his term of office expires in Oct., 1970. Before the expiration of his term of office, the newly established district shall elect his successor.

9th District. The present councilor shall serve until his term of office expires in Oct., 1970. Before the expiration of his term of office, the newly established district shall elect his successor.

The alternate councilor-elect shall serve until his term of office expires in Oct., 1971. Before the expiration of his term of office, the newly established district shall elect his successor.

10th District. The councilor-elect shall serve until his term of office expires in Oct., 1971. Before the expiration of his term of office, the newly established district shall elect his successor.

The present alternate councilor shall serve until his term of office expires in Oct., 1969. Before the expiration of his term of office, the newly established district shall elect his successor.

11th District. The present councilor shall serve until his term of office expires in Oct., 1969. Before the expiration of his term of office, the newly established district shall elect his successor.

The alternate councilor-elect shall serve until his term of office expires in Oct., 1971. Before the expiration of his term of office, the newly established district shall elect his successor.

12th District. The present councilor shall serve until his term of office expires in Oct., 1970. Before the expiration of his term of office, the newly established district shall elect his successor.

The present alternate councilor shall serve until Oct., 1971, a year after his present term of office expires, to avoid having a councilor and alternate councilor elected by the district in the same year. Before the expiration of his extended term of office, the newly established district shall elect his successor.

13th District. The councilor-elect shall serve until his term of office expires in Oct., 1971. Before the expiration of his term of office, the newly established district shall elect his successor.

This plan will provide for 13 councilors at all times. Four will be elected in 1969; four in 1970, and five in 1971. Thus, in 1971, all councilors will represent the new districts as defined in this resolution.

BE IT FURTHER RESOLVED, that each newly established district shall determine the proper procedure for it to follow in election of its representative on the Board of Directors of Blue Shield.

Resolution No. 68-11

Introduced by: THE COUNCIL
Subject: IMPLIED CONSENT LAW

WHEREAS, evidence has shown that in accident cases where blood is automatically drawn to test the alcoholic content that the number of accidents have been reduced, and,

WHEREAS, drinking drivers are becoming an increasing menace to the life and safety of others on the highway,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association prepare and introduce a bill in the 1969 session of the legislature providing that any person licensed to drive and driving on an Indiana highway and becoming involved in an accident shall undertake a blood test to determine the alcoholic content of his blood, and,

BE IT FURTHER RESOLVED, that such law provide that the physician at the scene of the accident shall draw the blood or blood may be drawn at the request of an officer of the law investigating the accident, and,

BE IT FURTHER RESOLVED, that the medical profession of the state of Indiana aggressively support such legislation.

Resolution No. 68-12

Introduced by: THE MARION COUNTY MEDICAL SOCIETY
Subject: CREATION OF A SECTION ON CUTANEOUS MEDICINE

WHEREAS, there are now forty-four (44) full-time dermatologists in the state of Indiana, and,

WHEREAS, these physicians are organized into an Indiana Society of Dermatology, and,

WHEREAS, the Indiana Society of Dermatology has expressed a desire to have a Section on Cutaneous Medicine established, and,

WHEREAS, the goal is to offer closer liaison and cooperation with organized medicine in problems confronting this body, and,

WHEREAS, it is the desire of the Indiana Society of Dermatology to offer its assistance in contributing to the continuing education program, to comprehensive health planning and to the Indiana plan,

NOW, THEREFORE, BE IT RESOLVED, that the House of Delegates of the Indiana State Medical Association establish a Section on Cutaneous Medicine as a separate entity aside, and distinct from, the other clinical sections now authorized by the Constitution and Bylaws and in accordance with Chapter III, Section 1, and XXXIII, Section 1, of the Constitution and Bylaws of the Indiana State Medical Association.

Resolution No. 68-13

Introduced by: GRANT COUNTY MEDICAL SOCIETY
Subject: OCHAMPUS PROGRAM

WHEREAS, the medical aid to military dependents known as OCHAMPUS was first begun on an experimental program in Indiana to show that the state medical organization could operate a usual and customary fee for service operation at a reasonable expense, and,

WHEREAS, this program has had many flaws in the usual and customary fee schedule, and,

WHEREAS, payment under this system has been delayed as long as six months to some of our members, and,

WHEREAS, other government payments are made more promptly even though not done through our Indiana State Medical Association,

NOW, THEREFORE, BE IT RESOLVED, that this House of Delegates discern the proper committee to investigate the action and needs of the program with an aim to improving the service or switching it to another agency for administration.

Scientific Exhibits

KENNETH G. KOHLSTAEDT, M.D., *Indianapolis, Chairman*

CONSERVATIVE THERAPY OF STASIS ULCERS

Exhibitor: Bert Seligman, M.D., Toledo, Ohio

Attendant: Bert Seligman, M.D.

Basic pathology and presenting symptoms in the development of chronic venous insufficiency leading to ulceration are illustrated by medical drawings and photographs. Diagnostic procedures are described and illustrated followed by clinical results of topical enzyme-antibiotic therapy in the treatment of leg ulcers.

PHYSICIAN-NURSE COMMUNICATIONS

Exhibitor: D. Ann Sparmacher, R.N., Chicago, Ill.

Attendant: D. Ann Sparmacher, R. N. (Mrs.)

The exhibit "Physician-Nurse Communications" represents a visual summary of the objectives and program of the American Medical Association's Committee on Nursing. Its purpose is to emphasize the importance of high standards of patient care through a close physician-nurse relationship. In an effort to protect and foster an enduring alliance of understanding and cooperation between the medical and nursing professions, the committee instituted a continuing program of liaison, communication, education, and research. These areas are highlighted in the exhibit by four interlocking circles which illustrate the four facets of the AMA program. The three general assumptions on which the AMA Committee on Nursing program is based are listed as follows: (1) that nurses have a separate and distinct professional status and their contributions are those of co-workers; (2) that nursing should expect the medical profession to support and endorse high standards of nursing education and nursing service; and (3) that each of the various levels of academic and technical accomplishment in nursing makes its own unique contribution to the total health care of the public.

SURGICAL CORRECTION OF THE CICATRICIAL ALOPECIAS

Exhibitor: Dowling B. Stough, III, M.D., Hot Springs, Ark.

Attendant: Geneva T. Wood, doctor's assistant

The scientific exhibit entitled "Surgical Correction of the Cicatricial Alopecias" shows the effectiveness of the "hair transplantation" procedure, through the display of color transparent photographs of outstanding cases over the past seven years. These photos show the results of patients, before and after undergoing this technic, in such conditions as traumatic lesions of the scalp, cicatricial alopecia due to disease, and such rare conditions as congenital absence of eyebrows and permanent forms of alopecia areata.

A similar exhibit with different photos was the recipient of the Aesculapius Award which was presented to the most outstanding scientific exhibit at the 1967 Arkansas State Medical Meeting. Another exhibit was presented to the XIII International Congress of Dermatology in Munich, Germany. A new but similar exhibit was presented to the American Academy of Dermatology meeting in Chicago, December 2-7, 1967, at which time considerable interest was manifested concerning the cicatricial alopecias.

A complimentary article, in association with the present exhibit, entitled "Surgical Improvement of Cicatricial Alopecia of Diverse Etiology," has been published in the March, 1968, *Archives of Dermatology*, and will be available for distribution at the meeting.

TOMOGRAPHY OF THE TEMPORAL BONE

Exhibitor: Wright Otologic Institute, Indianapolis

Co-Exhibitors: Clifford Taylor, M.D., A. J. Miller, M.D., J. William Wright, Jr., M.D.

This exhibit explains the method used in polytomography for examination of the temporal bone including both the middle ear and inner ear. The principles of polymography are shown.

Normal polytomes in the AP and lateral view of the ear are demonstrated along with the normal oblique view. The normal course of the seventh nerve is shown by actual polytomography studies. Other polytomes, accompanied by LogEtronic adaptation which clarifies the original polytome, show cases of injury to the seventh nerve, cholesteatoma, tumor of the seventh nerve, tumors of the eighth nerve, tumors in the mastoid, fractures of the temporal bone with brain abscess, fistulas of the lateral semicircular canal, injury and dislocation of the ossicular chain, congenital anomalies of the inner and middle ear as well as otosclerosis.

The principle of the LogEtronic adaptation of the original polytome is explained and illustrated.

Selected slides of various other types of ear pathology, which are clarified by the use of the polytome, are shown on a automatic viewer with an accompanying taped explanation which will accommodate three listeners and observers at a time.

The whole presentation is designed to show the advantages of polytomography in the diagnosis of temporal bone disease.

INDIANA STATE FLYING PHYSICIANS ASSOCIATION

Exhibitor: William D. Dannacher, M.D., Wabash, Ind.

Attendant: William D. Dannacher, M.D.

There are about 150 flying physicians in Indiana and about 2,000 nationally. The members are all M.D.'s who have an interest in aviation for business and pleasure. Most of the doctors have their own airplanes; others lease or belong to flying clubs. Many members are flight examiners.

The purpose of the F.P.A. is to promote safety in flying. The F.P.A. also is organized to fly medical personnel and equipment to a disaster area on short notice when these services are requested. The F.P.A. also is interested in the medical aspects of aviation, aviation personnel, pilots and tower operators.

The F.P.A. has flying trips to Mexico, Alaska, the Bahamas, West Indies and various parts of the United States. These group flights are connected with medical seminars in the various countries and lo-

calities where they go.

The exhibit shows some of their activities and personnel will be there to answer questions about general aviation and requirements for membership.

CONSERVING SURGICAL TREATMENT OF RHEUMATOID ARTHRITIS OF THE HANDS

Exhibitor: F. Robert Brueckmann, M.D., Indianapolis
Co-Exhibitor: James Strickland, M.D.
Attendant: James Strickland, M.D.

The exhibit on "Conserving Surgical Treatment of Rheumatoid Arthritis of the Hands" depicts, via colored slides and diagrams, the pathologic development of bone and tendon erosion due to persistent synovitis. Modes of non-surgical treatment are mentioned but main attention is directed to early excision of diseased active synovial tissue which has resisted medical management. As the disease becomes more advanced, the problems of ulnar drift of the fingers, poor grasp and dislocation of the metacarpal-phalangeal joints are cared for by arthroplasty to improve hand function.

DOES YOUR GIRL BELONG?

Exhibitor: Indiana State Association of Medical Assistants, New Albany, Ind.
Attendants: Mrs. Louise McComb, Miss Martha Merkle, Mrs. Mary Girardot

The purpose of an exhibit by the Indiana State Association of Medical Assistants is to acquaint the medical men of our state with our organization—our ideals, our value to the medical profession as an organization, our educational objectives and the fact that by our Constitution, this organization can never become a union or be used as a bargaining agent.

We usually use a mannequin dressed as a "medical assistant" and have brochures relating to our activities, aims and objectives to give to the physicians in attendance at the ISMA convention. We also have at least one girl in the booth at the required hours to talk with the doctors and answer their questions about ISAMA. Also the doctors at times will give the name of their aides to the attendant and ask for further information to be sent to them.

We extend a heartfelt welcome and an eager invitation to all of the doctors of ISMA to visit the booth of the ISAMA and see what they can discover about this organization that will benefit their own aides.

TRANSFUSE PACKED RED BLOOD CELLS

Exhibitor: Fort Wayne Regional Red Cross Blood Center, Fort Wayne, Ind.
Attendants: Margaret J. Ball, M.D., Harry R. Garton, M.D.

Color photos describe the advantages and indications for use of packed red blood cells in transfusing patients. Pamphlets available for distribution.

THE ADVANTAGES IN THE USE OF SPECIFIC BLOOD COMPONENTS IN TRANSFUSIONAL THERAPY

Exhibitor: Community Blood Bank of Marion County, Inc., Indianapolis
Attendant: Mrs. Ruth M. Lee

The exhibit consists of a film strip preparation with narration designed to point out some of the blood components available for use today. Specific advantages in the use of given components are described and explained by accompanying charts. Particular attention is given to the use of packed red cells, frozen plasma, platelet rich plasma and platelet concentrates, and anti-hemophiliac factor-rich cryoprecipitates.

HEMOGLOBIN S

Exhibitor: W. P. Loh, M.D., Gary, Ind.
Attendant: W. P. Loh, M.D.

The growing population of the Negroid race in Gary has increased the exhibitor's interest and experience in Hemoglobin S. This exhibit presents a simplified understanding of Hemoglobin S and the exhibitor's personal experience and research data concerning rapid detection of Hemoglobin S. Hemoglobin S is explained in terms of definition, discovery, molecular structure and hemodynamics in the pathologic physiology involved. Sickle cell disease is presented in the form of basic pathology and interesting clinical features. Color photographs are used for the illustrations. It is beyond the scope of this exhibit to give a complete coverage of all clinical features. To date there is no possible treatment.

The detection of Hemoglobin S requires sodium metabisulfite sickling test or hemoglobin electrophoresis or hemoglobin solubility test. The advantages and the disadvantages of each technic are discussed.

INDIANA PLAN FOR CONTINUING MEDICAL EDUCATION

Exhibitor: Indiana University School of Medicine, Indianapolis
Attendant: George T. Lukemeyer, M.D., Elmer Friman, Ray Collins or Seymour Friedberg

The purpose of the Indiana University School of Medicine exhibit is to demonstrate the progress of the Indiana Plan for Statewide Medical Education. The focal point of the display will be a television monitor and videotape recorder which will make the exhibit a part of the telecommunications system which now joins the principal hospitals and the state university campuses. Components of this network are used for continuing medical education, for graduate medical education, and for undergraduate medical education as a part of the new Indiana University School of Medicine curriculum. The monitor and videotape recorder will demonstrate the various uses of the telecommunications system.

Photographs, charts and drawings will document and interpret the progress of the Indiana University Plan to create a unique educational environment in Indiana as an effective and immediate means to provide the citizens of Indiana with sufficient numbers of practicing physicians.

THE PROBLEM OF THE ENLARGED HEAD

Exhibitor: Division of Neurosurgery, Indiana University Medical Center, Indianapolis
Attendants: John Kalsbeck, M.D., and Julius M. Goodman, M.D.

Abnormal or rapid head enlargement in infancy is a frequent diagnostic problem referred to the Pediatric Neurosurgery Clinic at Riley Hospital of the Indiana University Medical Center. This exhibit illustrates some of the causes of the large head and outlines methods of diagnosis and treatment.

By far the most common etiology of head enlargement is hydrocephalus. In this condition there is obstruction of the spinal fluid pathways at various points within the ventricular system, basal cisterns or absorptive surfaces. Hydrocephalus may result from developmental defects

such as stenosis of the aqueduct of Sylvius or obliteration of the exits of the fourth ventricle and from acquired lesions such as tumors, infections and subarachnoid bleeding. The site of obstruction is usually demonstrated by air encephalography. Treatment is by shunting spinal fluid into the blood stream or various body cavities.

Subdural hematomas secondary to trauma and subdural effusions following meningitis may also cause head enlargement. Diagnosis and treatment is by subdural taps. Megencephaly, subarachnoid cysts, arteriovenous malformations involving the vein of Galen, achodroplasia, and Hurler's disease are among some of the other conditions associated with a large head.

Technical Exhibitors—1968

ABBOTT LABORATORIES Booth 41
14th and Sheridan Rd. North Chicago, Ill.

AMES COMPANY Booth 26
1127 Myrtle St. Elkhart, Ind.

ARNAR-STONE LABORATORIES, INC. Booth 69
601 E. Kensington Rd. Mt. Prospect, Ill.
William Snider

ASTRA PHARMACEUTICAL PRODUCTS, INC. Booth 66
7 Neponset St. Worcester, Mass.
David E. DeWine

AUDIO ELECTRONICS WHOLESALE Booth 52
319 W. Maryland St. Indianapolis, Ind.
James L. Grunder

AUTOMATED MANAGEMENT SYSTEMS, INC. Booth 18
5016 Knoll Crest Ct. Indianapolis, Ind.

AYERST LABORATORIES Booth 64
685 Third Ave. New York, N.Y.

BRISTOL LABORATORIES Booth 35
P. O. Box 657 Syracuse, N.Y.
S. L. Brenner

BURROUGHS WELLCOME & CO. (U.S.A.) INC. Booth 29
1 Scarsdale Rd. Tuckahoe, N.Y.

CIBA PHARMACEUTICAL COMPANY Booth 10
556 Morris Ave. Summit, N.J.

THE COCA-COLA COMPANY Booth 50
P. O. Drawer 1734 Atlanta, Ga.

CONTROL-O-FAX ACCOUNTING SYSTEMS Booth 63
131 Hoss Rd. Indianapolis, Ind.
C. F. Cole, J. Johnson, K. Sidebottom, D. Sargent

DE PUY MANUFACTURING CO., INC. Booth 33
P. O. Box 4988 Warsaw, Ind.

DICTAPHONE CORPORATION Booth 61
120 Old Post Rd. Rye, N.Y.

DOME LABORATORIES Booth 70
West Haven, Conn.
Robert Swift

FIRST EQUITY SECURITY LIFE INSURANCE CO. Booth 32
321 Citizens Bank Bldg. Anderson, Ind.
Ethel B. Benefiel

GEIGY PHARMACEUTICALS Booth 67
444 Saw Mill River Rd. Ardsley, N.Y.

GERBER PRODUCTS COMPANY Booth 9
445 State St. Fremont, Mich.
Joe Madigan

GRAHAM ELECTRONICS SUPPLY, INC. Booth 51
122 S. Senate Ave. Indianapolis, Ind.
Jim Douglas

J. E. HANGER, INC. OF INDIANA Booth 30
1332 N. Illinois St. Indianapolis, Ind.

IBM OFFICE PRODUCTS DIVISION Booth 38
Fort Wayne, Ind.

IMPERIAL FASHIONS Booth 60
553 S. Western Ave. Los Angeles, Calif.

INDIANA BELL TELEPHONE COMPANY Booth 3
240 N. Meridian St. Indianapolis, Ind.

INDIANA BLUE SHIELD Booth 31
110 N. Illinois St. Indianapolis, Ind.
Herbert P. Dixon, Richard C. Kilborn, Fritz D. Harbridle, Gary R. Miller

INDIANA BRACE, INC. Booth 48
1815 N. Capitol Ave. Indianapolis, Ind.

LEDERLE LABORATORIES Booth 14
Middletown Rd. Pearl River, N.Y.

ELI LILLY AND COMPANY Booth 15
P. O. Box 618 Indianapolis, Ind.
C. D. McKay, J. E. Aufderheide, D. R. Hollingsworth

LOMA LINDA FOODS Booth 27
Box 388 Mt. Vernon, Ohio
D. C. McFeters, George Smothermon

MARION LABORATORIES, INC. Booth 55
10236 Bunker Ridge Rd. Kansas City, Mo.
Charles W. Feld, Joseph F. Gajdostik

MEAD JOHNSON LABORATORIES Booth 56
2404 W. Pennsylvania Ave. Evansville, Ind.
William H. Lee, Bruce Sanders

MEDCO PRODUCTS COMPANY, INC. Booth 49
3601 E. Admiral Pl. Tulsa, Okla.

THE MEDICAL PROTECTIVE COMPANY Booth 16
Fort Wayne, Ind.
Kenneth W. Moeller, Philip P. Capasso

MERCK SHARP & DOHME Booth 42
West Point, Pa.
T. P. Moriarty, E. D. Haustveit, J. D. Collier

MERRILL LYNCH, PIERCE, FENNER & SMITH Booth 47
229 W. Berry St. Fort Wayne, Ind.
William LaGrand, Larry Roberts, Ron Venderly, Bill Stearley, Dave Lamberson, Joe Daniel

MILEX CENTRAL COMPANY Booth 20
1873 Grove St. Glenview, Ill.

MUNCIE AVIATION CORPORATION Booth 53
P. O. Box 1169 Muncie, Ind.
Paul E. Rupprecht, Jr.

NORTH AMERICAN PHARMACAL, INC. Booth 19
6851 Chase Rd. Dearborn, Mich.
Richard Brackvogel, John Koretka, Don Swiggett

ORTHO PHARMACEUTICAL CORPORATION Booth 1
Raritan, N. J.
Tom Jackson, Jeff Conn

PARKE, DAVIS & COMPANY Booth 12
GPO Box 118 Detroit, Mich.
J. R. Stambaugh, G. M. Morehouse

PFIZER LABORATORIES Booth 62
235 E. 42nd St. New York, N.Y.

PROFESSIONAL MANAGEMENT Booth 45
2424 Fairfield Ave. Fort Wayne, Ind.
Paul Evans, Harold Neff, L. Thomas Booth, Tommy Gregg, Jack Osborn, Joseph Parker, George White, Marvin Ballard, Jack Koenig, Richard Lusk, Berton Bryan

QUAKER CITY PHARMACAL COMPANY Booth 34
1034 S. 54th St. Philadelphia, Pa.

RAJKUMAR CLOTHIERS Booth 24
P. O. Box 6422 Kowloon, Hong Kong

A. H. ROBINS COMPANY **Booth 17**
1407 Cummings Dr. Richmond, Va.
Jim McKinney, Jack Deddin

ROCHE LABORATORIES **Booth 23**
Roche Park Nutley, N.J.
Ron Ranus, William Parker, William Bissey, John Christoph

J. B. ROERIG DIVISION (Chas. Pfizer & Co., Inc.) **Booth 65**
235 E. 42nd St. New York, N.Y.

ROSS LABORATORIES **Booth 25**
625 Cleveland Ave. Columbus, Ohio

SANDOZ PHARMACEUTICALS **Booth 68**
Route #10 Hanover, N.J.

W. B. SAUNDERS COMPANY **Booth 57**
7th and Locust St. Philadelphia, Pa.
Gerald Gervase

SCHERING CORPORATION **Booth 44**
1011 Morris Ave. Union, N.J.

CLAYTON L. SCROGGINS ASSOCIATES **Booth 22**
141 W. McMillan St. Cincinnati, Ohio
Lee W. Scroggins

G. D. SEARLE & CO. **Booth 2**
P. O. Box 5110 Chicago, Ill.
William H. Meyer, W. H. Eagan

SIEMENS MEDICAL OF AMERICA, INC. **Booth 58**
60 W. Fay Ave. Addison, Ill.

SMITH KLINE & FRENCH LABORATORIES **Booth 21**
1500 Spring Garden St. Philadelphia, Pa.

SMITH, MILLER & PATCH, INC. **Booth 54**
902 Broadway New York, N.Y.
John S. Fleming

E. R. SQUIBB AND SONS **Booth 28**
745 Fifth Ave. New York, N.Y.
L. E. Lee

STRYKER CORP. **Booth 3**
1115 Chatfield Dr. Indianapolis, Ind.
John A. Clarke, Mrs. John A. Clarke, Don Schaffner, Lloyd Shoukwiler

STUART DIVISION, ATLAS CHEMICAL INDUSTRIES, INC. **Booth 11**
3360 E. Foothill Blvd. Pasadena, Calif.

SYNTEX LABORATORIES, INC. **Booth 36**
Stanford Industrial Park Palo Alto, Calif.

3M BUSINESS PRODUCTS SALES, INC. **Booth 6**
4830 Lima Rd. Fort Wayne, Ind.
Richard Garab, Orvel Miller, James Cole, Richard Longenerker, Ron Kersten, Stan Budzon, Bill Evans, Dean Allison, Dave Helbert

J. RUSSELL TOWNSEND, Jr., ADMINISTRATOR, CONTINENTAL CASUALTY INSURANCE **Booth 5**
811 Board of Trade Bldg. Indianapolis, Ind.
J. Russell Townsend, Jr., William F. Davis, Edgar H. Baum, Walter Fries

WARNER-CHILCOTT LABORATORIES **Booth 7**
201 Tabor Rd. Morris Plains, N.J.
Alen Drazner, Michael Murphy, Fred Roberts, Ray Warren, Bill Zwick

WESTERFIELD LABORATORIES, INC. **Booth 46**
3941 Brotherton Rd. Cincinnati, Ohio

WINTHROP LABORATORIES **Booth 43**
90 Park Ave. New York, N.Y.
Moody Cross, J. H. Hooper, R. E. Erdmann, J. L. Jones

Reserve Your Room Today — for the 119th Annual Convention of the Indiana State Medical Association — Fort Wayne, Indiana — October 15, 16, 17 and 18, 1968

Listed below are the motels and hotels and their rates; also a reservation request form. All housing requests are to be made through the **Fort Wayne Convention and Visitors Bureau, 310 Central Building, Fort Wayne, Ind. 46802.**

ROOM RATES

HOTELS AND MOTELS IN AND AROUND FORT WAYNE, INDIANA

HOTELS

NAME & ADDRESS	# ROOMS	SINGLES	DOUBLES	TWINS	SUITES
INDIANA HOTEL 131 W. Jefferson	200	$5.50 to 8.00	$7.00 to 10.00	$8.00 to 11.00	
KEENAN HOTEL 1006 S. Harrison	300	$7.50 to 10.00	$9.50 to 12.00	$12.50 to 15.00	$16.00 up
VAN ORMAN HOTEL 128 West Berry Street	300	$7.00 to 10.00	$10.50 to 11.50	$13.50 to 16.00	$16.00-1 rm. 25.00-2 rms.

MOTELS AND MOTOR HOTELS

BAER FIELD INN Baer Field	80	$9.00 to 10.50	$11.50 to 15.00	$14.50	$29.50
COUNTRY CLUB MOTEL 6010 U.S. #24	30	$5.00 to 7.00	$7.00 to 8.00	$8.00 to 10.00	
FOUR WINDS MOTEL 1004 W. California Road	60	$9.00	$12.00	$13.00	
GERBER-HAUS MOTEL 1011 E. California Road	125	$9.00	$12.00	$14.00	$17.50 up
HOLIDAY INN MOTEL 3730 E. Washington	128	$8.00 to 9.00	$11.50 to 13.50	$11.50 to 13.50	
HOWARD JOHNSON'S MOTOR LODGE 4332 U.S. 30 E.	104	$9.50- 10.50	$13.00- 14.50	$14.50 & 15.00	
KEY MOTOR HOTEL Lincoln Hiway West	125	$8.00 to 8.50	$10.00 to 10.50	$10.00 to 14.00	
VAN ORMAN NORTHCREST 515 California Road	65	$9.00 to 10.50	$11.00	$13.00 to 18.00	$21.00
WAYNE MOTEL 7001 New Haven Avenue	51	$7.00	$8.00	$9.00	
TRAVELODGE	75	$10-$12	$12-$16	$16-$18	$35.70

* Connecting rooms available at most hotels and motels.
** Cots are available at a small additional charge.
*** All above listed motels are within 3½ miles from downtown Fort Wayne.

— Mail to —

Date ....., 1968

ISMA Housing
Fort Wayne Convention and Visitors Bureau
310 Central Building
Fort Wayne, Indiana 46802

Please reserve — ( ) single ( ) twin ( ) double ( ) suite
at hotel or motel:

....
(first choice) (second choice) (third choice)

Rate requested .....

It should be understood that the next higher room rate will be assigned if requested rate is not available.

Arrival date ..... a.m. p.m.

Departure date ..... a.m. p.m.

....., M.D.

.....
Street address

.....
City Zip Code

The S.S. HOPE—A Modern Medical Center

ARTHUR BAPTISTI, JR., M.D.
Indianapolis*

HAVING served on three of HOPE's six completed missions I conclude, as most all others who have participated in this unique venture do, that service as a "HOPIE" is the highlight of one's medical career.[1] The hospital ship HOPE affords a physician the opportunity to practice medicine as he dreamed he eventually would when he entered medical school—healing the sick without the encumbrances of finances, telephones, politics and all the other factors which may make urbane medical practice a job rather than a joy—with the additional opportunity of teaching our medical skills to others who not only need but want such instruction.

NEW symbol of HOPE.

Background

Project HOPE (Health Opportunity for People Everywhere) is the principal activity of The People-to-People Health Foundation, Inc., of Washington, D.C., an independent, non-profit corporation. Its objective is to teach medical, dental and paramedical personnel in developing countries the latest technics of U.S. medical science. Its teaching "workshop" is the S.S. HOPE.

The 15,000-ton Navy hospital ship U.S.S. CONSOLATION was refitted, loaned to the Foundation in 1960, and renamed the S.S. HOPE. The ship left San Francisco on September 22, 1960, for her maiden voyage to Indonesia and South Vietnam. Missions followed to Peru (1962-63), Ecuador (1963-64), Guinea (1964-65), Nicaragua (1966), and Colombia (1967). HOPE now is in Ceylon (1968-69). Each mission averages ten months. Since HOPE's first voyage, more than 1,100 American medical personnel have served with the project.

The S.S. HOPE is permanently staffed with nurses, technologists and several physicians. Supplementing the permanent staff are volunteer teams of physicians, surgeons and dentists in twenty specialties who are flown to the ship for two-months' service without pay. Meanwhile, HOPE teams throughout the country examine patients, sending to the ship for hospital care the cases which are most urgent or medically instructive.

HOPE teams conduct continuing programs in four countries: In Peru, Ecuador, Nicaragua and Colombia. All continuing programs have been requested by the governments of the visited nations and remain after the ship has departed.

Accomplishments

In eight years HOPE doctors, nurses and technologists have trained 4,017 physicians, surgeons, dentists, nurses and technologists; treated over 120,000 persons; conducted some 10,778 major operations; benefited more than two million people through immunization, examination and other services; and distributed 2,474,000 cartons of milk. The work of HOPE has been documented in two books—*A Ship Called HOPE* and *Yanqui, Come Back!* Each is written by William B. Walsh, M.D., HOPE's founder and president.

About $5 million is needed annually to sustain the operation of the S.S. HOPE and Project HOPE's land-based programs. The project depends primarily on private resources and receives tax-free contributions from thousands of individuals and groups, including support from organized labor, business and industry.

Organization

William B. Walsh, M.D., is founder, president and medical director of Project HOPE. Headquarters are in Washington, D.C. Field offices are in New York City, Philadelphia, Boston, Chicago, Detroit, Los Angeles, Atlanta, Washington, D.C., Rochester (N.Y.), Minneapolis, Indianapolis, San Francisco, Cincinnati and Miami. In addition, HOPE has volunteer chapters and committees in major cities throughout the United States. The Foundation is incorporated under the charitable and educational provision of the District of Columbia code. It enjoys tax-exempt status with the Internal Revenue Service of the U.S. Government.

The HOPE ship is a modern hospital with 100 beds for patient care and much of the most desirable equipment for teaching that is available today. There is closed circuit television and video tape recorders, in addition to many other types of conventional visual aids for teaching. There is a language laboratory and a medical library which is adequately stocked with current texts and journals, all donated by American medical publishers. In each major medical specialty, local physicians receive postgraduate training by serving as residents on the ship. These residencies vary from one to four months

* Marion County General Hospital, Indianapolis 46202.

and are usually in high demand by local doctors. These appointments are made by the local medical society or medical school and not by Project HOPE. All of the medical personnel of the ship have local counterparts so that not only local physicians but also local nurses—both graduate and student—and local technicians, medical secretaries, medical librarians, etc. are trained by the "HOPIES."

All of HOPE's services in foreign lands are rendered without charge. Patients who are treated on the ship are admitted from a waiting list made up from a HOPE screening clinic conducted by HOPE physicians in an on-shore hospital. Patients are referred to the screening clinic by their local doctors and are put on the waiting list only if they are good teaching cases or in urgent need of care which is not available in the local hospital.

Reflections

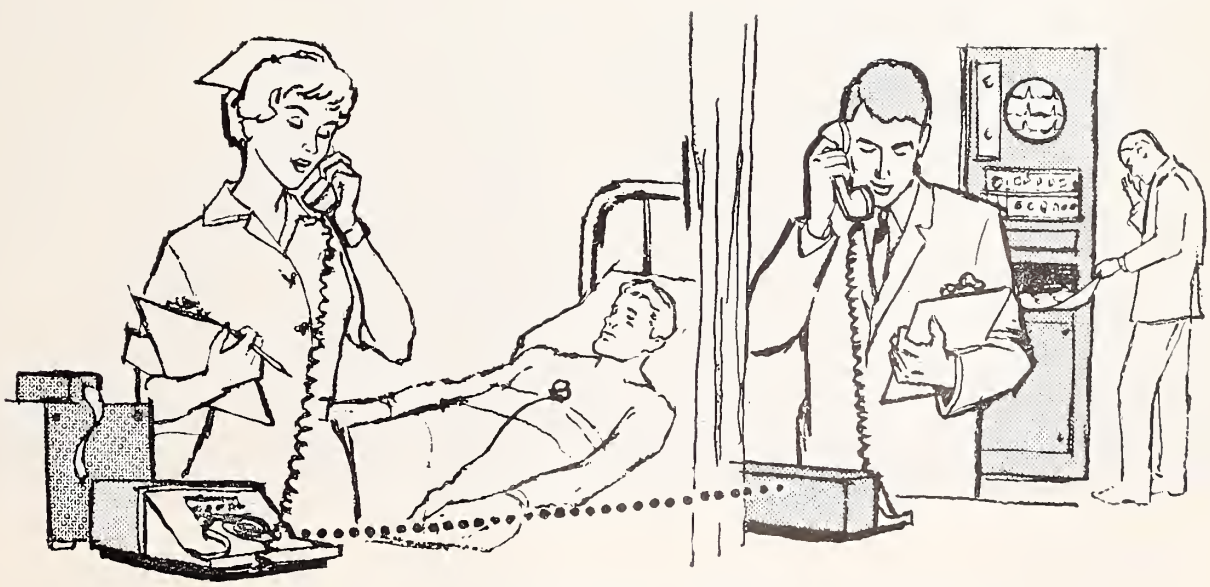
The S.S. HOPE—the world's first peacetime hospital ship—is an outstandingly unique venture in foreign aid. There is incontestable evidence that its missions, which operate only in countries where it is invited by that nation's medical group with government approval, are highly successful not only in the interchange of knowledge and technics of modern medicine but also in promoting international friendship and goodwill on a fundamental people-to-people basis. Each year's mission, accomplished for the bargain price of $5 million dollars, provides a legacy of learning which benefits the visited country long after the ship has departed.

This cost of one mission is unique in many ways. It is unique as a bargain—it is less than the cost of one jet bomber. It is furthermore unique in that this money is not drained off the American economy. Virtually all of the cost of a HOPE mission is paid to Americans— American Maritime Union Sailors who maintain the ship throughout its mission; American nurses; American technicians; American medical secretaries; etc. All of these people are Americans. Thus, the money stays in America. This is a noteworthy feature in these days when America is suffering an unfavorable balance of currency.

A voluntary medical rotation service of two months is recommended as a delightfully rewarding and memorable experience. An application for service on the S.S. HOPE or on one of its land-based programs may be obtained by writing Project HOPE, Washington, D.C. 20007. Indiana physicians may also obtain further information from HOPE's regional field office at 700 N. Alabama St.. Indianapolis 46204. ◄

REFERENCES

1. Baptisti, Arthur, Jr.: The Post-HOPE Syndrome, *Obstet. Gynec.* 21:646, 1963.



NOW–Practical Centralized Expert Analysis

The Bell System DATA PHONE service concept makes possible transmission of electrocardiograms, electroencephalograms and X-ray data via the regular telephone network. It's fast and economical. Call your Indiana Bell Business Office about it today.

Indiana Bell
Part of the Nationwide Bell System

Tandearil® in Osteoarthritis
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.
Warning: Tandearil is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.
Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.
Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reacti-

"Pain Break" for an osteoarthritic.

Tandearil can usually ease it.

At 46, her knees still look good on the outside. But inside, there may be the familiar picture of osteoarthritis.

If aspirin doesn't help, Tandearil often will. Pain and stiffness begin to ease up in 3 or 4 days. You can often maintain response with a daily dose of only 1 or 2 tablets.

Of course, Tandearil is not for every osteoarthritic. Select your patients carefully and follow them in line with the Contraindications, Precautions, Warning, and Adverse Reactions listed below.

But for many aspirin-stubborn osteoarthritics, let Tandearil ease the unwelcome pain breaks of osteoarthritis.

Tandearil®
oxyphenbutazone

vate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis) or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity, angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

For complete details, please see full Prescribing Information.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily. In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and other factors influencing drug response
Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

Geigy

(B) 46-800-A

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

TA-8106AR

Orient Medical Tour

WEI-PING LOH, M.D.
Gary

AN Orient Medical Tour was successfully sponsored and conducted by the Marion County Medical Society for members of the Indiana State Medical Association in June. Approximately 165 physicians and their families participated in the tour under the chairmanship of W. P. Loh, M.D., Program Committee, and Joseph H. Tuckman, M.D., Travel Committee. They spent one week in Japan and another week in Hong Kong, from June 15-June 29, 1968. Many of the physicians also toured through Bankok, Thailand. The guest speakers in Japan and Hong Kong were superb, and their lectures were thoroughly enjoyed. The medical program is as follows:

Program in Tokyo Area

June 18, Tuesday: National Health Insurance in Japan (Haruo Katsunuma, M.D., Professor and Head, Dept. of Public Health, University of Tokyo).

June 18, Tuesday: Advances of Diagnosis and Surgical Management of the Upper G.I. Diseases With Endoscopy (Takeo Hayashida, M.D.. Professor and Chief, Dept. of Surgery and Hospital Director, Tokyo University Branch Hospital). The lecture was followed by demonstration of gastrocamera (Olympus Company).

June 19, Wednesday: Cardiovascular Diseases in Japan, especially Aortitis Syndrome and Buerger Disease (Dr. Hideo Ueda or Dr. Iwao Ito, University of Tokyo).

June 19, Wednesday: Diet, Growth and Atherosclerosis in Japan (Dr. Yoshiyata Takahashi, University of Tokyo).

June 19, Wednesday: Clinicopathological Studies on the Mediastinal Tumors in Japan (Shigeru Hatano, M.D., Professor of Surgery, University of Tokyo).

June 19, Wednesday: Gastroduodenal Ulcers in Japan (Minoru Oi, M.D., Professor and Director, Dept. of Surgery, Jikei University School of Medicine).

ARRIVAL of the Orient Medical Tour in Hong Kong, June 23, 1968.

June 19, Wednesday: Gastric and Esophageal Carcinomas in Japan (Komei Nakayama, M.D., Tokyo Women's Medical College).

June 20, Thursday: Birth Control and Abortions in Japan (Professor S. Tojo or Professor M. Mochizuki, Dept. of Obstetrics and Gynecology, Kobe University School of Medicine).

June 20, Thursday: Ovarian Tumors in Japan (Professor Kato, M.D., Dept. of Obstetrics and Gynecology, Kurume University School of Medicine).

June 21, Friday: Several Rare Neurological Disorders of Childhood (Tadao Takatsu, M.D., Professor of Pediatrics, University of Tokyo).

June 21, Friday: Interesting Hematological Disorders (W. P. Loh, M.D., Associate Professor, Chicago Medical School).

June 22, Saturday: A roundtable discussion: Diseases common and rare in Japan; Diseases which are apt to be brought back to the United States.

Program in Hong Kong Area

June 23, Sunday: Nasopharyngeal Carcinoma (Dr. H. C. Ho, Queen Elizabeth Hospital, Kowloon, Hong Kong).

June 24, Monday: Cryptogenetic Splenomegaly and Recurrent Pyogenic Cholangitis (Professor A. J. S. McFadzean, Dean, University of Hong Kong).

June 24, Monday: Thalassaemia in Chinese (Dr. David Todd, University of Hong Kong).

June 25, Tuesday: Immunological Aspects of Infection with Clonorchis Sinensis (Dr. T. Sun, Dept. of Microbiology, University of Hong Kong).

June 25, Tuesday: Visit to Hay Ling Chau Leprosarium.

June 26, Wednesday: Visit to University of Hong Kong Medical Center.

June 28, Friday: Hydatidiform Mole (Professor Daphne Chun, Dept. of Obstetrics and Gynecology, University of Hong Kong).

June 28, Friday: A roundtable discussion: Diseases common and rare in Hong Kong; Diseases apt to be brought back to the United States (Professor G. B. Ong and others). ◄

in the treatment of
IMPOTENCE

Android®
(thyroid-androgen) TABLETS

*Effectiveness confirmed by another double blind study**

1.SUMMARY
ANDROID — GOOD TO EXCELLENT 75%
PLACEBO — 20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

*"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of **4** *strengths*

Android
Each yellow tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY
Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY
Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C
Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

Write for literature and samples:
BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

REFER TO PDR

also available with ESTROGEN
Android-E
Each Tablet Contains:
Methyl Testosterone ..... 2.5 mg.
Ethinyl Estradiol ..... 0.02 mg.
Thyroid Ext. (1/6 gr.) ..... 10 mg.
Thiamine Hydrochloride ..... 10 mg.
Glutamic Acid ..... 50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE:** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS:** In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRA-INDICATIONS:** See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

GLEANED FROM THE BRITISH MEDICAL JOURNAL

JACK W. HICKMAN, M.D.
Indianapolis

British M.D. Exodus to U.S. Evaluated

The "brain drain" dates back clearly to the early 1960's. In the 1962-64 period, about 300 M.D.'s per year, over one-sixth of the annual output of the British medical schools, emigrated from Great Britain. Noting the magnitude of this emigration, a board was formed by the Ministry of Health to investigate the causes of this phenomenon. The board also hoped to discover ways that might encourage these physicians to return to Great Britain. In its report the board mentions increased income, the greater availability of research monies and greater freedom of practice as major reasons for the physicians' move to the "New World."[1] The board also noted that licensure and certification difficulties confront the physician who is interested in returning to his native land. The weakest part of the report is in the summary, in which it appears as though the board forgot its own findings in preparing its recommendations. It tends to stress better orientation regarding practice opportunities, career guidance and application procedures. It seems unlikely that these weak efforts, even if adopted, would stem the tide.

Drug Control of Hypertension Full of Side Effects

A well-controlled clinical study to evaluate the hypotensive effects of methyldopa, bethanidine and guanethidine is reported by Prichard et al.[2] It should be mentioned that the "et al." includes Sir Max Rosenheim, who, among other things, is President of the Royal College of Physicians of London. The study was performed on only 30 patients, but each patient served as his own control during the study, and each was thoroughly evaluated. The authors found that methyldopa gave a very nice physiological control of hypertension in those patients who were able to tolerate it. Unfortunately six of the 30 patients could not tolerate it because of the side effects and one further patient was forced to discontinue it because of drug-induced diarrhea. Neither bethanidine nor guanethidine was well tolerated either. Guanethidine had less tendency to produce the quite major symptom of postural hypotension, but even so, it was not a frequent first choice of the patients studied. Bethanidine was the best tolerated by the patients, but it had the highest incidence of postural hypotension. The search for antihypertension agents must go on.

Cranial Bruit Observed in Three Types of Severe Anemia

It is always refreshing to see new physical findings that are described by individual practicing physicians. One of the last that I can recall was the finding of retinal stippling in patients suffering from lead poisoning. A brief report by Bareboo from Oldchurch Hospital, Romford, Essex seems to be of the same character.[3] The author reports that he observed cranial bruits in three patients suffering from severe blood loss anemia. These patients were observed in a nine month period. He has also observed similar bruits in three patients with pernicious anemia and in others with iron-deficiency anemia. In all patients, the cranial bruits disappeared when the hemoglobin level was corrected to roughly 75% of normal. He speculates that the bruit may be caused by turbulent flow in the cerebral arteries because of decreased blood viscosity, vasodilatation and increased cardiac output. It will be interesting to watch for confirmatory (or contrary) observations by others.

REFERENCES

1. Emigration of British Doctors to United States of America and Canada, Ministry of Health Interview Board, *Brit. Med. J.* 1:45-48, No. 5583.
2. Prichard, B. N. C., et al.: Bethanidine, Guanethidine, and Methyldopa in Treatment of Hypertension: a Within-patient Comparison, *Brit. Med. J.* 1:135-144, No. 5585.
3. Bareboo, H.: Severe Anaemia as a Cause of Cranial Bruit in Adults, *Brit. Med. J.* 1:294, No. 5587. ◄

Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension

Enduron: (methyclothiazide) A basic building block for mild hypertensives

Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

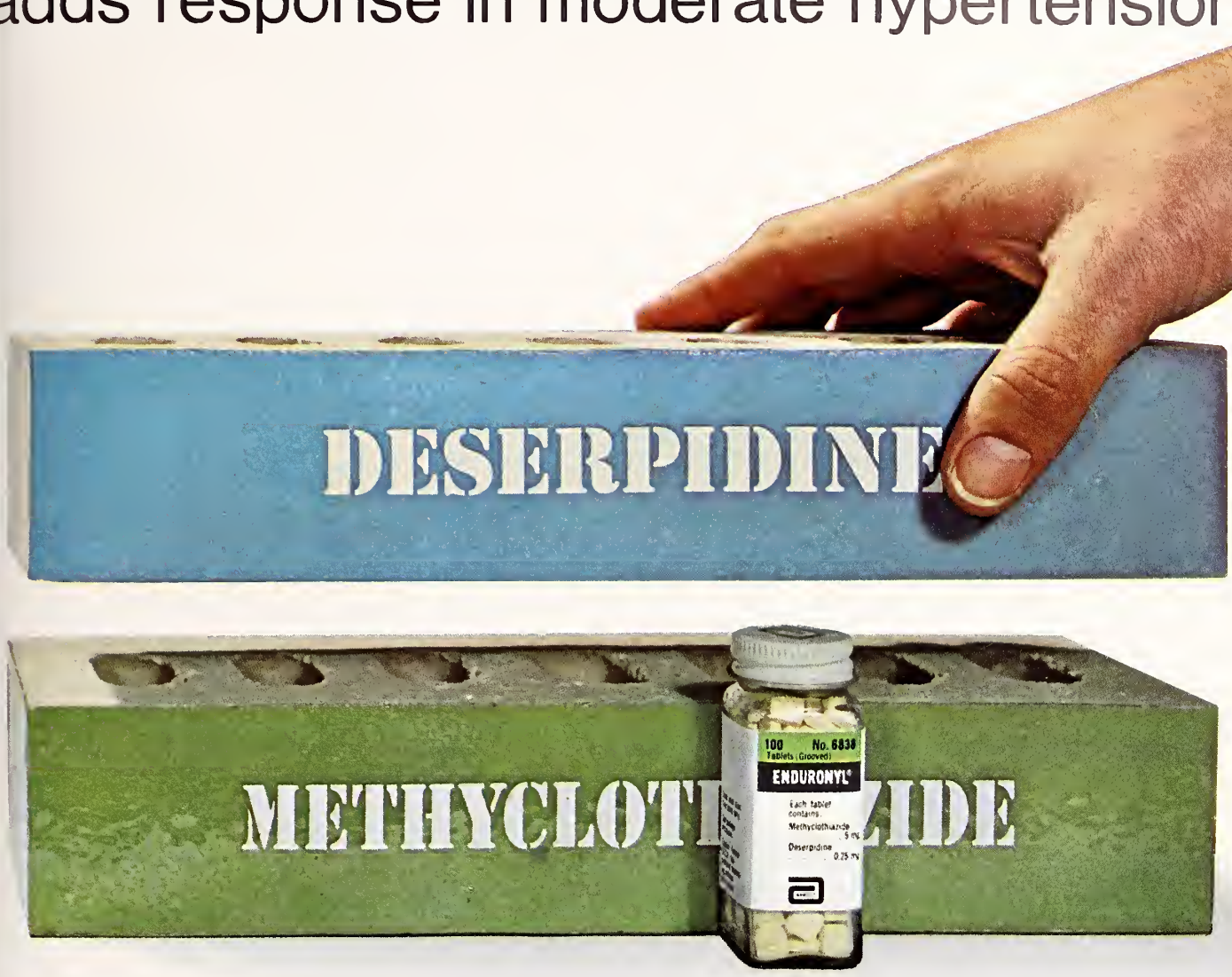
ENDURON®

METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVERE

See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

Once a day, every day

ENDURONYL®

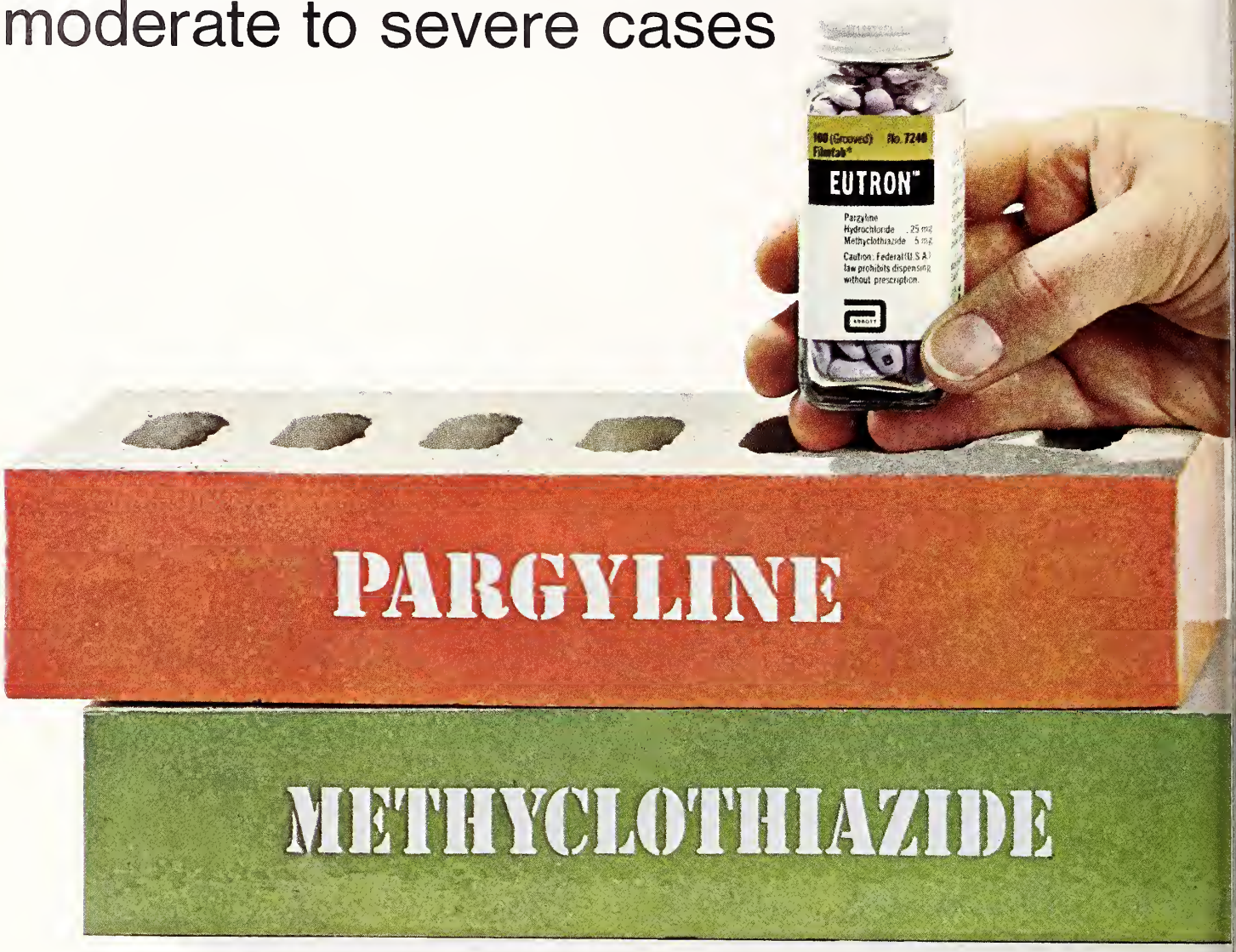
METHYCLOTHIAZIDE 5 mg. with DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

MILD TO MODERATE TO SEVERE

See Brief Summary on final page of advertisement

801094

Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE

See Brief Summary on final page of advertisement

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions—Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

ABBOTT

TM-TRADEMARK

The New State Board Examination

*MERRITT O. ALCORN, M.D.**
Madison

For many years there has been concern over the essay type of examination used by the Indiana Licensing Board because of the small volume of information covered, difficulty in impartial grading and delay in obtaining grades.

In recent years there have been as many foreign graduates taking the Indiana examination as United States graduates, although, there are very few foreign graduates taking postgraduate training in this state. Many of them come from Illinois and Ohio and return by reciprocity to these states if they pass the Indiana examination. This puts Indiana in the uncomfortable position of licensing physicians for other states which give a more comprehensive type of examination.

The new FLEX examination (Federation Licensing Examination) is prepared by the Federation of State Medical Boards from the National Board of Medical Examiners Examination Bank. Questions are carefully selected to evaluate ability to practice medicine. The examination is in three parts, each part requiring one day. The first is basic science material, the second portion covers clinical subjects and the third part is a practical application of knowledge examination with film strips of patients and other methods designed to measure ability to examine, diagnose and treat patients.

This examination was first given in June, 1968, by seven states, including Illinois and Ohio. The reaction by all boards involved was one of enthusiasm.

The President's Commission on Health Manpower has expressed its concern over the amount of licensing of graduates of inadequate medical schools. This group has specifically recommended that the National Board Examination be used to evaluate all foreign graduates; however, Dr. John Hubbard, President of The National Board of Examiners, has pointed out that the Federation Examination is specifically designed for licensing and would be the appropriate examination. This is apparently acceptable and now it remains a question of whether the states are able to go to this level of examination or whether federal licensing legislation will be necessary.

The Indiana State Medical Board has unanimously agreed to use this examination and has received endorsement by the Indiana State Medical Association and the administration of the Indiana University School of Medicine. The only obstacle remaining is that the Medical Practice Act must be changed because it specifies an examination fee of $25.00 and a fee of $75.00 is needed to cover costs of the Federation Examination.

The Indiana Board of Medical Registration and Examination is asking that this change be made by the 1969 Indiana General Assembly and needs the support of physicians throughout the state.

* President, Indiana State Board of Medical Registration and Examination.

The hospital-proven system that belongs in your office

The UNITEST SYSTEM of blood chemistries offers speed, accuracy, reproducibility, simplicity and economy. You can obtain important diagnostic test results while your patient is still in the office. Bio-Dynamics' UNITEST SYSTEM meets the exacting standards of the trained medical technologist, but can be used by other office and laboratory assistants, after brief training.

The 10 basic test kits contain everything necessary for 12 direct-reading tests and six additional determinations . . . 18 vital clinical answers.

TEST KITS NOW AVAILABLE: GLUCOSE, HEMOGLOBIN, CHOLESTEROL, B.U.N. URIC ACID, BILIRUBIN, TOTAL PROTEIN, GLOBULIN, ALKALINE PHOSPHATASE, CREATININE.

Each test takes less than two minutes working time, costs under 70 cents. Tests are color coded, premeasured and disposable. Nothing wasted. No clean-up. Normal and abnormal controls are available to insure accurate results.

The precisely calibrated, solid-state Unimeter, with unique interchangeable meter faces, has unlimited capacity for additional tests. New meter faces are supplied as tests are developed.

The UNITEST SYSTEM is the leader in its field. More than 12,000 are now in use in offices, laboratories and hospitals. Sold and serviced by your local medical and surgical supply dealer. Ask for a free trial.

Bio-Dynamics, Inc.

9115 Hague Road, Indianapolis, Indiana 46250

DAY BY DAY WITH THE F.D.A.

The Florida Citrus Commission initiated action against a dairy products company in South Carolina. The commission's investigation showed that the "Pure Florida Orange Juice" which the defendants were selling contained at least 40% added water and less than 60% orange juice.

* * *

The states of Arkansas, Oklahoma and Texas have been the sites of numerous prosecutions in recent years for improper warehousing of foodstuffs. As a result five workshops were held in 1967 for food warehousemen. In addition another workshop is planned in Texas. The Texas Wholesale Grocers Association is the co-sponsor.

* * *

The death of a resident of Toledo, Ohio is being investigated. The man died with symptoms of lockjaw. He had been receiving injections of a Canadian cancer serum. The serum remaining after his death was found to contain Clostridium tetani. Numerous Canadian and U.S. officials are investigating.

* * *

As a result of the FDA cancellation of certification on chloramphenicol, Richlyn Laboratories and Vitamix Pharmaceuticals voluntarily recalled all outstanding previously certified lots. In the case of Richlyn, this amounted to three million capsules of 250 mg and 480,000 capsules of 100 mg strength.

Tetracaine hydrochloride in plastic 0.5 cc droppers was found by FDA to be at only 20% of declared potency. Repeated analyses established that the drug had apparently deteriorated because of some reaction with the container. All outstanding lots were recalled.

* * *

The Massachusetts Food and Drug Division has embargoed, pending Federal seizure, toy doctor-and-nurse kits containing unlabeled candy pills.

* * *

The train wreck which caused fire in a tomato cannery at Dunreith, Indiana, last January, necessitated immediate inspection by the Indiana Division of Food and Drug Inspectors to determine what, if any, of the canned vegetables could be salvaged. Salvage operations were hampered by chemical fumes, freezing weather and snow and sleet.

* * *

Cross-contamination of penicillin was investigated recently by the Indiana State Board of Health, Division of Food and Drugs. The investigation showed that the penicillin was contaminated in a retail pharmacy due to poor dispensing procedures involving a tablet counter. The Division and the Indiana Board of Pharmacy are making a joint effort to inform the state's retail pharmacists of this possible hazard.

The Kitchens of Sara Lee recalled $8,000 worth of pastries which had unaccountably become contaminated with a hydrocarbon of the nexane group and had produced at least one case of illness. Investigation and recall of the pastries was carried out voluntarily by the company with the assistance of FDA inspectors.

* * *

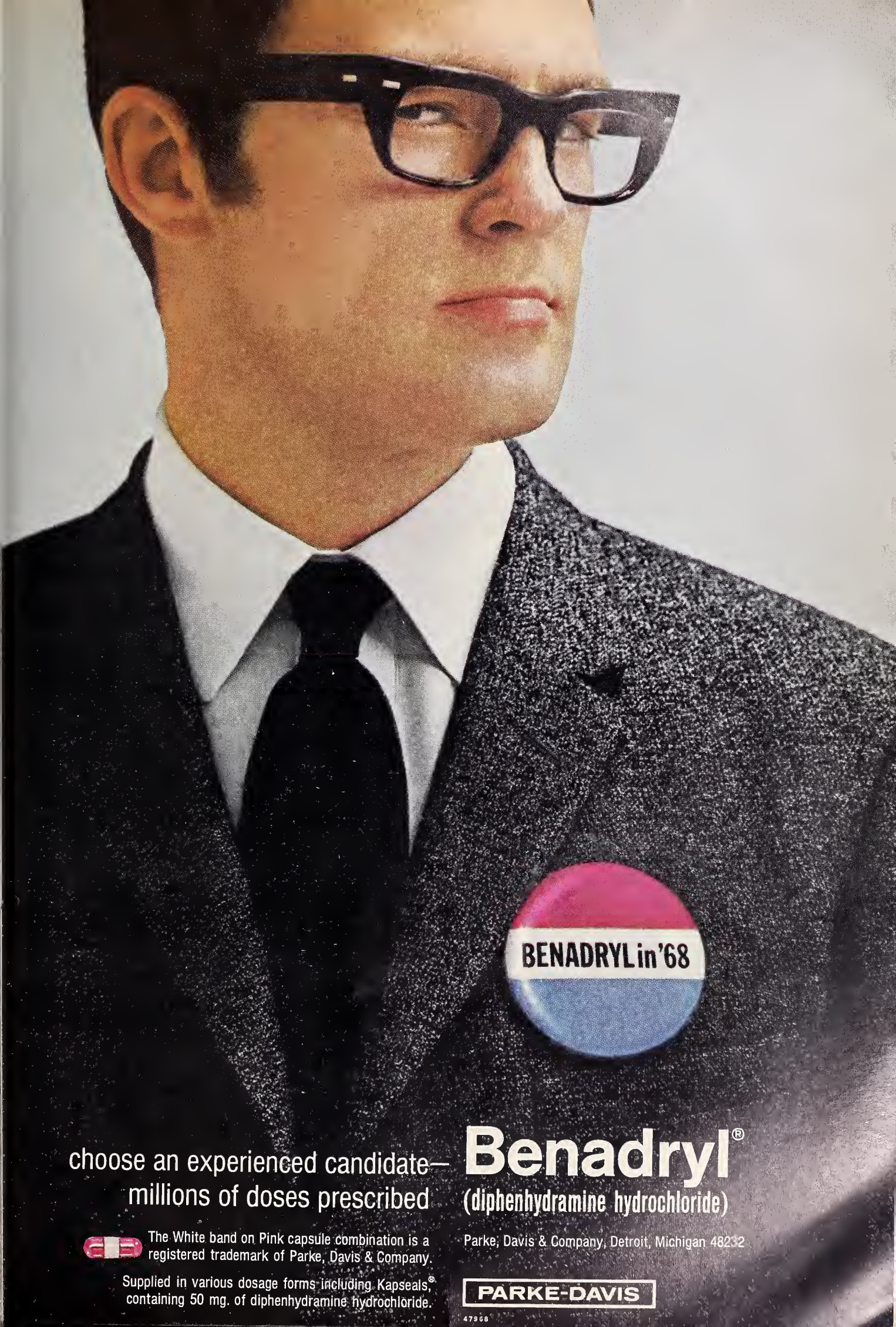
More than 23 million thyroid and thyroid-digitalis tablets promoted nationally for weight reduction were seized in January because of false and misleading labeling claims. The drugs were charged with being dangerous to health when used as prescribed, recommended or suggested in their labeling. Another lot of 15 million "Thyrodig" tablets was seized later in another state.

* * *

Seventeen Mexican children died and many more became ill recently as a result of eating baked goods. Investigation by Mexican health authorities showed the poisoning was due to parathion. The warehouse in Mexicali, which supplies the bakery concerned, was found to have parathion stored next to their supply of sugar. None of the baked goods is known to have entered the United States.

* * *

A farm in Texas produces carrots with intolerable amounts of endrin. The carrot field is next to a lettuce field which had received heavy doses of endrin in the past and may have become contaminated by drift of the endrin. Later, in 1966, the carrot crop was O.K. In 1967 the field was deep-plowed to be on the safe side—result—endrin in the carrots. Chemists think the deep plowing surfaced endrin which had been applied years before. Endrin is known to be persistent in soil. ◄



choose an experienced candidate—
millions of doses prescribed

Benadryl®
(diphenhydramine hydrochloride)

The White band on Pink capsule combination is a registered trademark of Parke, Davis & Company.

Supplied in various dosage forms including Kapseals,® containing 50 mg. of diphenhydramine hydrochloride.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

47968

When it's more than a bad cold

your patient can feel better while she's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

349-8

Dear Doctor:

Wouldn't you like your patients to learn more about the contributions made by the world of medicine to their welfare? So that they can better appreciate the efforts of the health team to keep them in good health?

To tell the stories of medical and pharmaceutical advances to people throughout the country, the Pharmaceutical Manufacturers Association is sponsoring a unique "magazine within a magazine." It is called *Medicines and your family's health* and the first issue appears in the November *Reader's Digest*.

We would like to send you 50 free reprints of *Medicines and your family's health* for use in your reception room. Your patients will find the articles in this issue factual, educational and of immediate personal interest.

Just fill out the coupon below and send it to us.

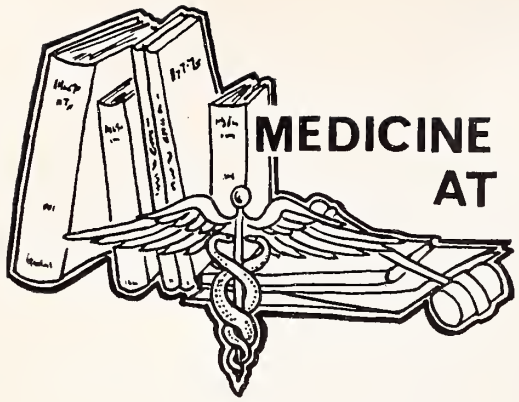
Order Desk
Pharmaceutical Manufacturers Association
1155 Fifteenth St., N.W.
Washington, D.C. 20005

Gentlemen:
Please send me 50 free copies of
Medicines and your family's health.

Name_____

Street_____

City_____ State_____ Zip_____



MEDICINE AT LAW

New Trial on Nerve Injury During Appendectomy—Proof that a patient's left ulnar nerve was injured in the course of an appendectomy established a prima facie case of negligence against the hospital, a Michigan appellate court ruled. However, a new trial was required because of false statements, made to the jury by the patient's attorney, that the hospital had failed to produce the operating table in response to a subpoena.

A hospital employee had positioned the patient on the operating table in preparation for the operation. She wrapped his left wrist with a cloth and put the wrist and the cloth in a cushioned wristlet. The wristlet was attached to an immovable metal bar at the side of the table. The patient testified that he did not recall any pad being placed under his elbow, as was the hospital's customary procedure. From the demonstration to the jury of the exact position of the patient's left arm, it appeared that it was in an uncomfortable position, pressing against the left side of his body. The patient testified that he complained of discomfort to the employee, but that she did nothing about it. The employee had no recollection of this particular operation, but she testified that if a patient complained of discomfort, she would examine and adjust the restraint to relieve the discomfort.

When the patient regained consciousness, he noticed that his left hand was "all pins and needles" and that his little finger and ring finger were absolutely numb. The numbness persisted. An examination by a neurologist disclosed that the patient's left ulnar nerve was injured. The neurologist testified that the injury occurred when the patient was strapped to the operating table. Both the physicians who performed the operation and the hospital employee testified that the ulnar nerve may be damaged if the patient's arm is improperly positioned on the table.

The evidence was sufficient to establish a prima facie case that the hospital was negligent and that its negligence was the proximate cause of the patient's injury. The hospital contended that the evidence was not sufficient because it did not prove, as was alleged in the complaint, that the hospital was negligent in having strapped the patient to the table too tightly. The evidence as to the relative position of the patient's body and the tension of all the straps came within the general language of the complaint, the court ruled.

While the hospital was presenting evidence about an experiment it had conducted with the operating table, the patient's attorney objected that he had subpoenaed the table but the hospital had not produced it. Actually, he had subpoenaed the anesthetist to produce the table. Since she was not a hospital employee, she had no control over the table and thus could not produce it. The hospital administrator later testified that the hospital had not been served with a subpeona to produce the table. In his argument to the jury, the attorney again stated that the hospital had failed to produce the table in response to a subpoena. The error in the attorney's first statement concerning the subpoena was cured by the administrator's testimony, and, if no further mention of the subpoena had been made, there would be no ground for reversal. However, permitting the misstatement as to the subpoena in the attorney's closing argument to stand constituted reversible error.—*Koepel v. St. Joseph Hospital and Medical Center*, 155 N.W.2d 199 (Mich., Dec. 1, 1967).

Chronic Alcoholic May Be Punished for Public Drunkenness—Conviction of a chronic alcoholic on a charge of public drunkenness was affirmed by the Washington Supreme Court. The application of the public drunkenness statute to a chronic alcoholic was not unconstitutional.

The accused was arrested when he was found sprawled on a public sidewalk in a drunken stupor. The record clearly showed that he was a chronic alcoholic.

The accused contended that his conviction was unconstitutional because he was being punished for conduct that he could not control or avoid. Assuming that he may not have had the will to avoid drinking to the point of intoxication, the court said, his conduct was not so involuntary as to compel him to become drunk in public.

The accused's conviction did not violate the constitutional prohibition against cruel and unusual punishment. He was convicted for his conduct in public while drunk, not for the condition or status of being a chronic alcoholic. Chronic alcoholism is not the legal equivalent of insanity.

Laws prohibiting public drunkenness bear a manifest relationship to the public peace, health, safety, morals, and welfare. Such laws are therefore a legitimate exercise of the police power.

The accused contended that if the courts refused to punish chronic alcoholics for public drunkenness, society would be compelled to substitute a more humane and enlightened form of treatment directed toward the rehabilitation of chronic alcoholics. There was no evidence produced showing that such has been society's reaction in those places where chronic alcoholics are no longer punished for public drunkenness. Further, it would not be a legitimate exercise of the judicial power for a court to try to compel the adoption of legislation and the expenditure of public funds for the attainment of seemingly desirable ends by refusing to uphold existing legislation.—*City of Seattle v. Hill*, 435 P.2d 692 (Wash., Dec. 21, 1967).

Surgeon Not Liable for Incision's Opening—A patient was not entitled to recover damages in a suit against a surgeon for injuries allegedly caused by the opening of the incision and subsequent efforts to close it. The doctrine of *res ipsa loquitur* did not apply, a Louisiana appellate court ruled.

Several days after the apparently successful removal of the patient's pyloric ulcer, the incision separated. The surgeon resutured the incision, using stainless steel wire sutures, which were to be left permanently in the patient. When the patient complained five months later of pain in the incision area, the surgeon operated a third time and removed eight of the wire sutures. The patient continued to have pain and consulted another surgeon. The second surgeon determined that there were two wire sutures still in the patient, but when he operated he deliberately left one in the patient because he thought it was in the patient's best interests to do so. A year later, a third surgeon removed the last wire suture and large amounts of calcification that had formed in the area.

The court rejected the patient's contention that the doctrine of *res ipsa loquitur* was applicable. The doctrine applies when, in the rendering of professional services, some untoward event, act, or omission occurs, resulting in something not ordinarily found to result from such treatment. In such a case, the physician is required to show that the unusual occurrence was not caused by negligence on his part. The patient failed to show any act or omission resulting in an unusual occurrence. He merely showed that the incision of an otherwise successful operation did not heal as desired or normally expected, and that as a result he experienced pain and suffering and loss of employment. The expert testimony clearly showed that everything that the surgeon did was in accordance with accepted standards of practice. At the time that he performed the third operation, the surgeon thought that there were nine sutures in the patient's body. The fact that he removed only eight was not evidence of negligence. He explained, as did the second surgeon, that leaving the suture in the patient was a matter of professional judgment.

The patient offered in evidence a pretrial deposition, and letters and reports to the patient's employer, in which the surgeon stated that he had removed all of the sutures in the third operation. The trial court stated that it did not consider the materials relevant on the issue of malpractice but admitted them since there was no objection by the physician. The trial court's comments as to the materials was not such as to constitute reversible error.—*Britt v. Travelers Indemnity Company*, 205 So. 2d 880 (La., Jan. 9, 1968).

VA May Sue Veteran for Hospital Services—The government may sue a veteran to recover the costs of hospital and medical services furnished at a VA hospital in treating him for a nonservice-connected disability, a federal appellate court ruled.

The statute provides that the VA may furnish hospital care to a veteran for a nonservice-connected disability if the veteran is unable to defray the expenses of necessary hospital care. The statute further provides that the veteran's statement under oath that he is unable to pay shall be accepted by the VA as sufficient evidence of his inability to defray necessary hospital expenses.

The veteran received treatment for a nonservice-connected disability on three separate occasions. On each occasion he signed a statement under oath that he was unable to pay the necessary hospital expenses. The government alleged that the statements were incorrect and erroneous in that the veteran was able to pay.

There is nothing in the statute which prohibits the government from collecting, after services have been rendered, from a veteran who is able to pay. The government, like any other owner of property, may have its property rights adjudicated by a court of competent jurisdiction. The government should not be more helpless than the private individual in obtaining relief from fraud, impostures, and deceptions.

The failure of the complaint to allege fraud was no bar to recovery. Restitution may be had for services rendered because of an innocent but material misstatement. — *U.S. v. Shanks*, 384 F.2d 721 (C.A. 10, Sept. 7, 1967; rehearing denied, Dec. 12, 1967).

Physician Liable for Sponge Left in Body—Judgment for a

Continued

patient in his suit against a physician who had to operate a second time to remove a sponge that had been left in the patient's body was affirmed by a Texas intermediate appellate court. The physician was responsible for the nurses' negligence in making the sponge count, and that negligence made the second operation necessary. The jury's award of damages of $1,000 was not so contrary to the weight of the evidence as to be clearly wrong.

The first operation was for the removal of the patient's spleen, which had ruptured. When the physician entered the abdominal cavity, he found it filled with old blood. Capillary oozing occurred when the spleen was removed. Those two conditions made necessary the use of an extremely large number of sponges. The evidence established that between 96 and 144 sponges were used in the operation. When the physician saw that he was near the end of the operation, he asked the nurses for a sponge count. They told him the count was correct. He then closed the incision. The physician testified that he relied on the nurses' count but also made a visual examination and saw no sponge.

After the patient was returned to his room, the nurses recounted the sponges and found that one was missing. They informed the physician. After waiting 12 hours to see what progress the patient made, he told the patient about the sponge and obtained his permission to remove it. The second operation took less than an hour. The patient thereafter made a good recovery.

The patient testified that he had pain a day or two after the operations and that he vomited after the second one. He stated that he now gets a pain in his side when he eats. The physician testified that the second operation did not delay the healing process and did not contribute to any ultimate disability.

The physician's testimony that he made a visual examination of the operational area before closing the incision raised a question for the jury as to whether he was personally negligent in leaving the sponge in the patient's body. The evidence clearly established that the nurses incorrectly counted the sponges. That the sponges might have been bloody or could have stuck together could not have caused the mistake. If that had happened, the total count would have been less than the number to be accounted for. There was no evidence that the count was necessarily hurried. The only conclusion possible was that the nurses were negligent in counting the sponges. Since the nurses were acting under the physician's direction and control, he was liable for their negligence under the doctrine of *respondeat superior*.

Relying on his visual examination and the nurses' count, the physician closed the incision, leaving the sponge in the patient's body. The negligent act led directly and proximately to a reasonably forseeable result, the second operation, and the physical pain and mental anguish caused thereby.—*Harle v. Krchnak*, 422 S.W.2d 810 (Tex., Oct. 5, 1967; on rehearing, Dec. 14, 1967; further rehearing denied, Jan. 4, 1968).

No Liability for Hepatitis Following Transfusion—A hospital and a surgeon won a directed verdict in a suit in an Illinois trial court by a patient who developed serum hepatitis following transfusion of two pints of blood in the course of an operation. The infection was held to be a "calculated risk" of blood transfusion.

The patient charged that the hospital had failed to comply with the standards of the American Association of Blood Banks with respect to the selection of donors. One pint was obtained from a blood bank; the other pint was obtained from a private donor who also gave blood for his own newborn child. An expert witness for the patient testified that she had needed only one pint of blood. On cross-examination, the witness admitted that only the surgeon could make the decision as to the amount of blood that was necessary.

An expert witness for the surgeon and the hospital testified that there is no known test by which the presence of the hepatitis virus can be detected. The director of a blood bank testified that the virus occurs in 0.3 percent of blood and that hepatitis is a calculated risk in blood transfusion. — *Loffredo v. Lawler*, Cir. Ct., Cook Co., Docket No. 63C-1361 (Ill., Feb. 16, 1968).

Hospital's Furnishing of Blood Not A "Sale"—A patient who developed serum hepatitis following a blood transfusion was not entitled to recover damages in a suit against a hospital for breach of implied warranty, a Florida appellate court ruled. The transfer of blood by the hospital to the patient was a "service," not a "sale." Since there was no "sale," there could be no implied warranty.

The blood had been purchased by the hospital from a blood bank and the cost was passed on to the patient, together with a service charge for furnishing equipment and labor. If there was any "sale" of the blood, the court said, it was between the blood bank and the patient.—*White v. Sarasota County Public Hospital Board*, 206 So. 2d 19 (Fla., Jan. 17, 1968; rehearing denied, Feb. 2, 1968).

the spasm reactors your practice deserve

"the Donnatal® Effect"

	each tablet, capsule or 5 cc. of elixir (23% alcohol)	each Donnatal No. 2	each Extentab®
mine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
e sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
e hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
rbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.
g: may be habit forming)			

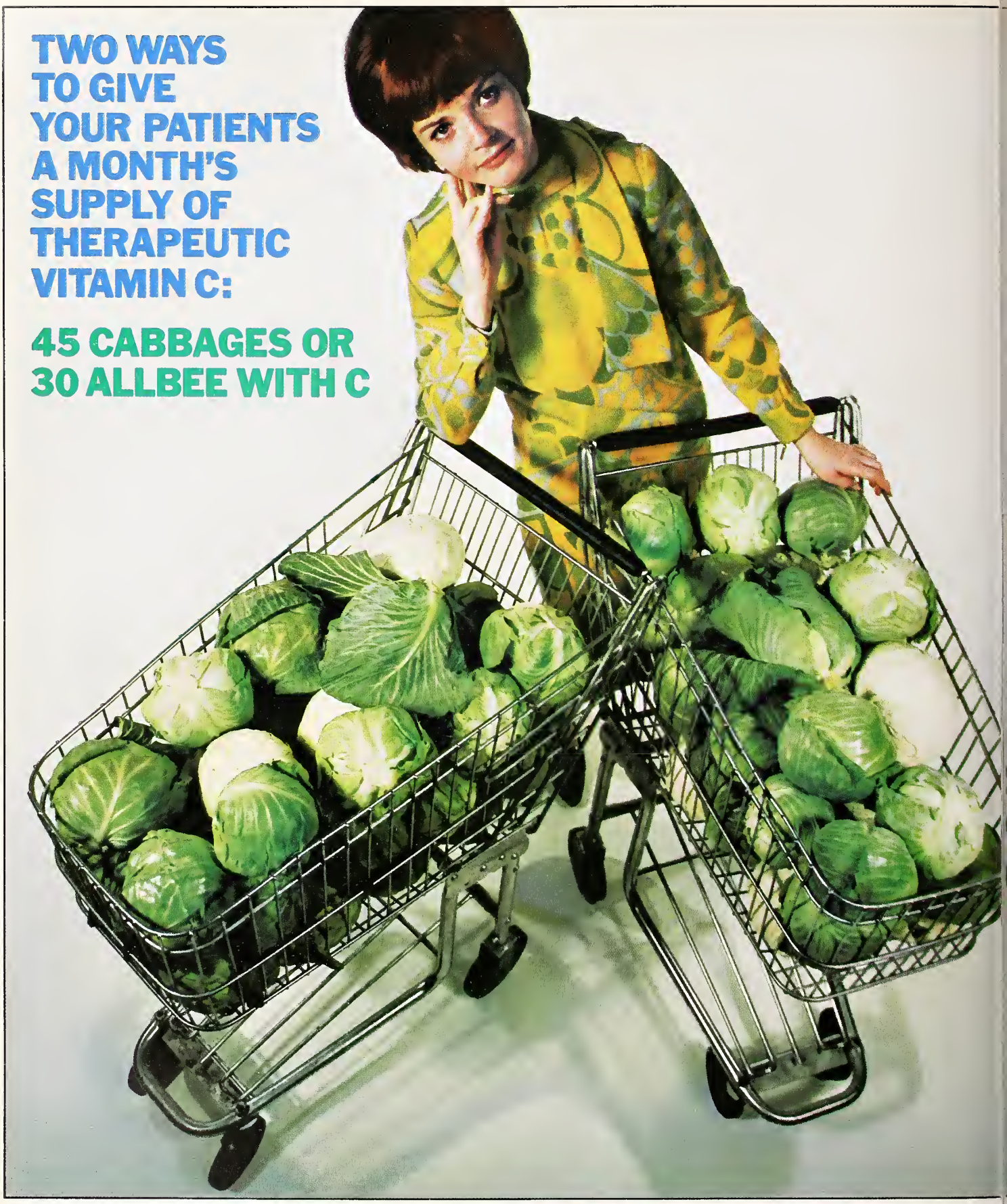
A. H. ROBINS COMPANY, RICHMOND, VIRGINIA 23220

Brief summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contra- indicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

A·H·ROBINS

TWO WAYS TO GIVE YOUR PATIENTS A MONTH'S SUPPLY OF THERAPEUTIC VITAMIN C:

45 CABBAGES OR 30 ALLBEE WITH C



Your patient would have to eat 45 cabbages a month (1-1/2 a day) to get as much vitamin C as is contained in just one bottle of 30 Allbee with C capsules (taken one capsule daily). In addition, each capsule provides full therapeutic amounts of the B-complex vitamins. For example, as much niacin as 2 pounds of sirloin steak.

Write "30" for B and C deficiencies. This handy bottle of 30 Allbee with C capsules gives your patient a month's supply at a very reasonable cost. Also the economy size of 100. Available at pharmacies on your prescription or recommendation.

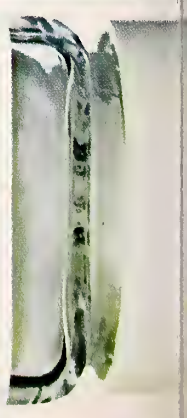
A. H. Robins Company, Richmond, Va. 23220.

A·H·ROBINS

Each capsule Contains:

Thiamine mononitrate (Vit. B_1)	15 mg
Riboflavin (Vit. B_2)	10 mg
Pyridoxine hydrochloride (Vit. B_6)	5 mg
Niacinamide	50 mg
Calcium pantothenate	10 mg
Ascorbic acid (Vit. C)	300 mg

30 Capsules
Allbee® with C



ABSTRACTS, BOOK REVIEWS

INTERNAL MEDICINE—BASED ON MECHANISMS OF DISEASE

Talso, P. J., Remenchik, A. P., The C. V. Mosby Company, St. Louis, 1968.

The editors prepared *Internal Medicine Based On Mechanisms of Disease* for a highly specific audience — namely, medical students and young house officers. To this end, they emphasized the basic mechanisms that underlie disease, the ways in which such disease processes induce signs and symptoms in human beings, and the fundamentals of obtaining data from patients —— all in a book of such size that the student could easily carry it.

Classifications are man-made and almost never conform perfectly to nature. Hence the classification on which this book is based is open to criticism. But, in first covering internal medicine as a science and an art, then discussing the basic mechanisms of disease, and finally covering the major consequences of the diseases that interest internists, the editors have achieved an organization that is certainly ingenious and well adapted for its purpose.

The first two sections of the book are especially useful from the standpoint of the neophyte in medicine. But the entire book, compressing the essentials of internal medicine into one brief volume, should not only be useful for students and house officers, but for any physician desiring a review of internal medicine. Particularly should it be of interest to general practitioners some years out of school and to physicians not in daily contact with patients. The editorial style is clear and easy to follow. the quality of paper, type, and illustrations is excellent.

This book is a product of Chicago medicine, since most of the contributors are from that city and its environs. As the editors point out, the scope of the book had to be limited in order to keep it compact. Still, I believe that body fluid disturbances might well have been included under basic mechanisms of disease. In addition, I wonder why the importance of potassium in heat stress disease did not receive emphasis.

This book is recommended for medical students, house officers and all physicians desiring a review of the essentials of internal medicine.

W. D. SNIVELY, JR., M.D.
Evansville

NUTRITION AND INFECTION

Ciba Foundation Study Group #31, edited by G. E. W. Wolstenholme and Maeve O'Connor, Little, Brown & Co., 1967; 144 pages with several tables and figures; $3.50.

The all too often reiterated tale of the efforts of protein deficiency upon human growth, development and resistance to disease is quietly but truly and forcibly presented by the experts who are leaders in the efforts launched world-wide to eradicate the underlying causes.

Just this morning, I happened to read in the newspapers that literally millions in Biafra will die this summer because of the civil wars riving Nigeria. All too often, we overlook the fact that newborn children *must* have the protein calories to permit their brains to develop to normal maturity. Otherwise, not only do they develop kwashiorkor: they also become permanently brain damaged! A final horrible speculation: how many school dropouts and "hard-core" unemployables are actually the consequence of subclinical but still very real "chronic protein calorie malnutrition"??

More of the members of our affluent societies ought to scan through this little volume: mayhap some unpalatable lessons will be driven close to home.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

PRINCIPLES OF INTERNAL MEDICINE

Edited by T. R. Harrison, R. D. Adams, I. L. Bennett, W. H. Resnik, G. W. Thorn, and M. M. Wintrobe, Blakiston Division, McGraw-Hill Book Company, fifth edition, New York, 1966; 1874 pages with illustrations; $22.50.

In comparison with previous editions, this new fifth edition presents significant improvement through extensive and excellent rearrangement and rewriting. The book provides consideration first of the cardinal manifestations of diseases and common syndromes, and only later the presentation of various diseases. It recapitulates the steps in the process of thinking by which a physician can reach his diagnosis. Such emphasis on clinical methods for a basic approach to medicine is unique and rewarding.

The editors and authors increased from 98 to 136, and pages increased from 1782 to 1816. Writings on new clinical manifestations and diseases which are uncommon in the USA are only a few of the new features. The presentations are highly readable

Continued

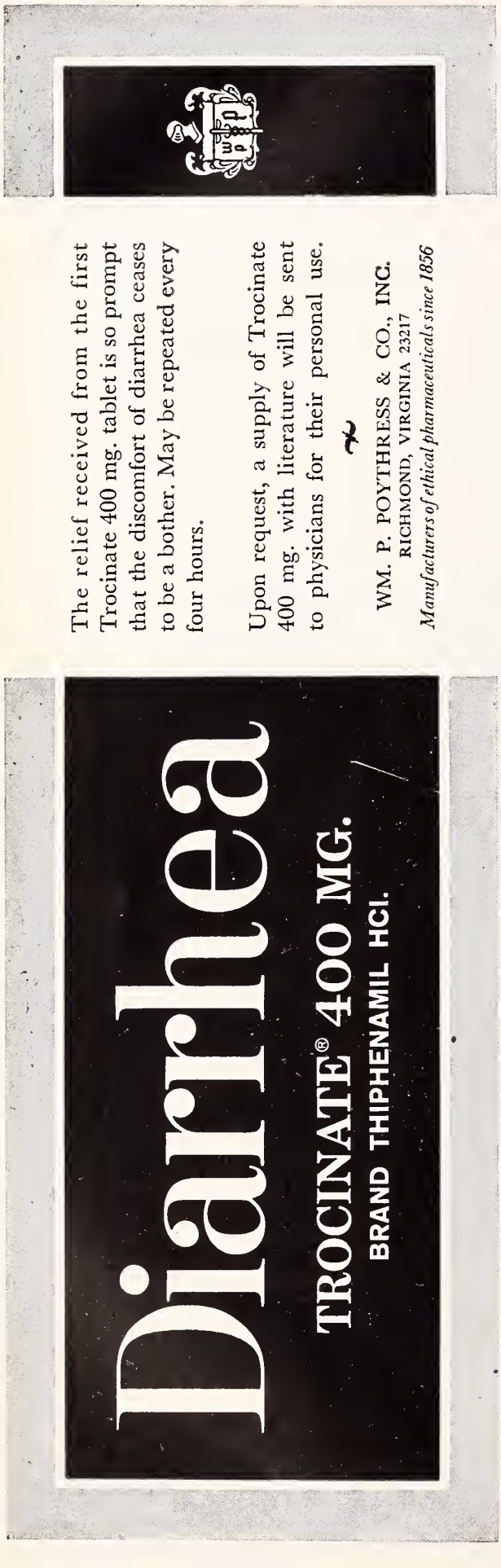
ESCORT YOURSELF . . .

to Home Lawn Mineral Springs for a few days health vacation —the mineral baths and excellent meals in an atmosphere of serenity will leave your cares behind and play golf on a beautiful course.

HOME LAWN
MINERAL SPRINGS
Martinsville, Indiana

M. C. Pitkin, M.D.
Medical Director

J. W. Gibbs, M.D.
Medical Director
Associate



Continued

and references up-to-date.

The editors and authors should be highly congratulated on the fine job which is well done. The book is well printed.

WEI-PING LOH, M.D.
Gary

DECISION MAKING IN NATIONAL SCIENCE POLICY

Ciba Foundation Symposium, edited by Anthony de Reuck, Maurice Goldsmith and Julie Knight, Little, Brown & Co., Boston, Mass., 1967; 310 pages; $12.00.

In the remote long ago of before World War II, scientists were ivory tower recluses eking out a modest existence; they had to scrounge around for equipment and laboratory space; "practical" business people were tolerantly amused. Well! Along came the Manhattan Project and everything changed.

Research and Development (R&D, in short) takes a budget of multibillions. The NHI finances the bulk of present day work in biology, medicine and all the allied fields. When Congress feels constrained to cut *back* on its R&D appropriations, emergency meetings by university big-wigs are held: can disaster be forestalled on the cloistered campuses?

The problems are not uniquely American. In this symposium, the policy makers from some twenty-odd nations present the problems facing them all. From super-powers USA and USSR down to tiny Israel, we hear their particular views. I found the ideas not exactly new. However, each discussant does help sharpen our overall view of the scientific community and its far ranging problems. Certainly, this is worthwhile reading for us all. It can be for all campus libraries; many hospitals would want to acquire this very excellent compendium.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

Abstracts From Various Literature, Prepared by AMA

LOW-TRYPTOPHAN DIET IN TREATMENT OF PSORIASIS

R. Carruthers (Lauceston General Hospital, Tasmania)
Med. J. Aust. 1:493-495, (March 23), 1968.

By limiting the tryptophan intake of patients with psoriasis, the disease regressed markedly in those who avoided foods which contained tryptophan. Itching stopped, the scaling lessened rapidly, and topical applications which had previously been ineffective caused regression of the dermal lesions of psoriasis (as judged by the disappearance of the dilated vessels of the dermal papillae). No untoward recurrence was observed in any of the patients when the diet was relaxed.

CONCEPTION CONTROL BY SINGLE MONTHLY INJECTION

A. Esquivel and L. E. Laufe (Western Pennsylvania Hospital, Pittsburgh)
Obstet. Gynec. 31:634-636, (May), 1968.

Seventy-three patients were given, during 929 menstrual cycles, a single injection of 1 ml of a new long-acting progestin-estrogen combination containing 150 mg of dihydroxy-progesterone aceto-

Continued

Does your assistant need an assistant?

Yes.
And she
has one.
At Blue Shield.

It takes a lot of business know-how to run your office smoothly and still have time to help out in a crisis, or listen to your patients, or act as your aid. It's a big job, and Medicare has made it even bigger.

Your assistant can do it all. But Blue Shield wants to make her job a little easier.

That's why we now have a representative available to come to your office when your assistant needs help in solving a Blue Shield problem.

That's also why we have a series of dinner-workshops each year to meet her specific needs, and why, along with our publications to you, we send the "News Capsule" to your assistant.

So if you want more time to care for your patients, make sure your assistant has an assistant. Blue Shield.

BLUE SHIELD
110 N. Illinois Street
Indianapolis, Indiana 46204

Continued

phenide and 10 mg of estradiol enanthate (Deladroxate) as a contraceptive. It induced consecutive monthly cycles of desquamation averaging 25.8 days in length with a range of four to nine days. The treatment was well tolerated, with a minimum of side effects. No pregnancies resulted. Among the clinic patients selected, there was a good acceptance of this method.

PREMATURE SIGNS OF PUBERTY FOLLOWING UNINTENTIONAL ESTROGEN ADMINISTRATION

R. Landolt (Kantonsspital, Kinderabteilung, Chur, Switzerland) and G. Murset

Schweiz Med. Wschr. 98:638-640, (April 27), 1968.

Following exposure to substances containing estrogen, four children (three boys and one girl) showed marked pigmentation of the nipples and areolas of the breasts. The girl also developed pubic hair and vaginal bleeding. In three cases the substance containing estrogen was a hair lotion and in one case an ointment. Forty cases described in the literature showed wide variations in the amount and mode of application of estrogen-containing substances. The most frequent signs were pigmentation of the nipples and areolas and enlargement of the breasts. Growth of pubic hair was less frequent. Vaginal bleeding occurred in some of the girls. After discontinuation of the substances all symptoms gradually receded, pigmentation usually disappearing last. Administration of estrogen-containing substances to children should be avoided.

BACTERIAL INTERFERENCE

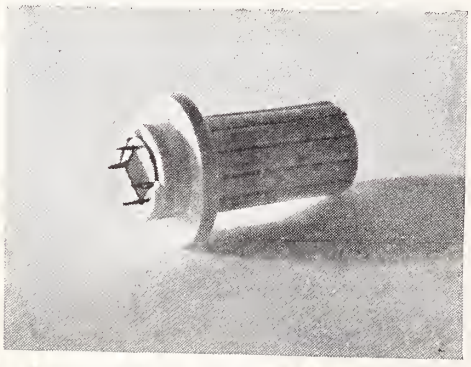
M. Boris et al. (S. J. Lagin, North Shore Hospital, Manhasset, N.Y.)

Amer. J. Dis. Child. 115:521-529, (May), 1968.

It is feasible to protect individuals from recurrent staphylococcal disease by artificially colonizing the nasal mucosa with *Staphylococcus aureus* 502A following antibiotic therapy. In a control group of 42 individuals treated only with antibiotics, the recurrence rate on the nasal mucosa of the original pathogenic strain was 74% (31 of 42). In the group inoculated with 502A after antibiotic treatment, 18 of 66 individuals reacquired the resident *S aureus*. The 502A strain once implanted persisted in 92% of the individuals at one month following implantation, 91% at three months, 85% at six months, and 67% at nine months. At the 12-month follow-up 58% still carried the strain.

To fight TB- find it first!

Make tuberculin testing routine with every physical examination.



TUBERCULIN TINE TEST (Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

Lederle

330-8/6136

MULTIPLE SCLEROSIS: THERAPEUTIC TRIAL WITH MENADIONE (VITAMIN K_3)

H. Henzi and A. Uehlinger (Kreisspital, Bulach, Switzerland)

Schweiz Med. Wschr. 98:688-690, (May 4), 1968.

A one year's therapeutic trial with menadione (menaphthone, vitamin K_3) was conducted in 14 multiple sclerosis patients. The results were analyzable in 12 patients: eight showed an objective improvement of neurologic deficiency symptoms, five experienced a 0.5 to 1 degree improvement in functional capacity, and six felt a subjective improvement. Diabetes mellitus was not observed.

PARABEN SENSITIVITY: SUBTLE TROUBLE

S. Epstein (University of Wisconsin Medical School, Madison)

Ann. Allerg. 26:185-189, (April), 1968.

The three cases presented here are proved instances of paraben sensitivity. The first case is an example of the insidious, readily overlooked form of generalized, disabling, and miserable dermatitis. Cases two and three demonstrate acute contact dermatitis caused by parabens. Cases one and three confirm the previous observations that patients with paraben dermatitis often also show strong contact sensitivity to other agents, especially topical medicaments.

CHRONIC SUBDURAL HEMATOMA IN THE ELDERLY: CURABLE LESION

R. Raskind et al. (Department of Neurological Surgery, The Permanente Medical Group, Kaiser Foundation Hospital, Oakland, Calif.)

J. Amer. Geriat. Soc. 16:451-457, (April), 1968.

Of 31 elderly patients who were treated surgically for chronic subdural hematoma, 34 survived the postoperative period; of these 30 were restored to their pre-illness states of activity and function; the remaining four had paraplegia or hemiparesis. Chronic subdural hematoma in patients past 60 years of age presents many difficulties in diagnosis; however, clues often may be elicited by careful inquiry into the history, thorough physical examination, echoencephalography, plain roentgenograms of the skull, and analysis of the cerebrospinal fluid. Subdural hematoma must be seriously considered in any person older than 60 with a history of recent personality changes, rapidly progressing senility, headaches, or neurological deficits, whether or not there has been any known trauma to the head.

CERVICAL INCOMPETENCY: A THERAPEUTIC ENIGMA

A. B. Weingold, J. I. Palmer, and M. L. Stone (New York Medical College-Metropolitan Hospital Center, New York)

Fertil. Steril. 19:244-262, (March-April), 1968.

Thirty-nine patients with cervical incompetency underwent 47 procedures resulting in a 74.5% fetal salvage rate. Current theories of multiple etiology and current varied treatment programs suggest that individualized application of a specific form of therapy should improve end results. A strong component of psychic and biochemical alteration underlies many supposed mechanical defects. Monitoring the in-utero environment by serial plasma diamine oxidase indicates deficits in the fetoplacental unit prior

Continued

When it's time for Thorazine® brand of chlorpromazine

...can you depend on less?

For profound calming effect in moderate to severe mental and emotional disturbances of everyday practice.

Before prescribing, see complete information, including adverse effects reported with phenothiazines and symptoms and treatment of overdosage, in SK&F literature or *PDR*. The following is a brief precautionary statement.

Contraindications: Comatose states or the presence of large amounts of C.N.S. depressants.

Precautions: Potentiation of C.N.S. depressants may occur (reduce dosage of such agents when used concomitantly). Use with caution in patients with chronic respiratory disorders. Antiemetic effect may mask overdosage of toxic drugs or obscure other conditions. Administer in pregnancy only when necessary. Because of possible drowsiness use cautiously and warn patients who operate vehicles or machinery.

Adverse Reactions: Drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; miosis; mild fever; weight gain; hypotensive effects, sometimes severe with I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosages (in rare instances, may persist); lactation and moderate breast engorgement (in females on high dosages); and less frequently, cholestatic jaundice (use cautiously in patients with liver disease). Adverse reactions occurring rarely, include: mydriasis; agranulocytosis; skin pigmentation; epithelial keratopathy; lenticular and corneal deposits (after prolonged substantial doses).

Available: Tablets, 10 mg., 25 mg., 50 mg., 100 mg. and 200 mg.; Spansule® capsules, 30 mg., 75 mg., 150 mg., 200 mg. and 300 mg.; Injection, 25 mg./cc.; Syrup, 10 mg./5 cc.; Suppositories, 25 mg. and 100 mg.

©1967, 1968 Smith Kline & French Laboratories

Smith Kline & French Laboratories, Philadelphia SK&F

to the clinical appearance of incompetency. In some cases, further compromise occurs after circlage. Retention of the fetus in an unfavorable environment may be reflected in an increased incidence of neurological deficit in infants living after successful maternal therapy.

FLUID AND SERUM ELECTROLYTE DISTURBANCES AS A COMPLICATION OF ENEMA IN HIRSCHSPRUNG'S DISEASE

P. K. Moseley and W. E. Segar (Section of Pediatrics, Mayo Clinic, Rochester, Minn.)

Amer. J. Dis. Child. 115:714-718, (June), 1968.

Water intoxication is a well-known complication of tapwater enemas in patients with Hirschsprung's disease. Two additional complications of enemas, hypernatremic dehydration and hyperphosphatemic tetany, were seen in children given hypertonic phosphate solution enemas——Travad and Fleet. Only isotonic enema solutions can be recommended for use in children with Hirschsprung's disease if potentially lethal derangements of fluid and electrolyte balance, such as salt and phosphate poisoning are to be avoided.

EFFECTS OF DEXTROTHYROXINE ON SERUM LIPOPROTEIN AND CHOLESTEROL LEVELS

R. L. Searcy (Hoffmann-La Roche, Inc., Nutley, N.J.), D. A. Hungerford, and M. Y. Low

Curr. Ther. Res. 10:177-186, (April), 1968.

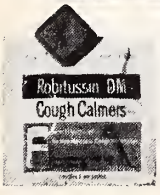
Oral doses of dextrothyroxine have been shown to depress serum total cholesterol levels in a majority of 48 hyperlipemic patients treated with the drug. Reductions in total cholesterol were largely reflected in the low-density lipoprotein spectrum, whereas changes in the high density were more variable. The fact that in most cases the hypolipemic responses could be maintained for prolonged periods suggests that the drug may be useful in managing hyperlipemia.

CONSERVATIVE MANAGEMENT OF PENETRATING ABDOMINAL WOUNDS

K. J. Printen, R. J. Freeark, and W. C. Shoemaker (627 S. Wood St., Chicago)

Arch. Surg. 96:899-901, (June), 1968.

Criteria used for operative management of abdominal stab wounds for the past six years at one institution include persistent or increasing tenderness, increasing severity or degree of tenderness, rebound tenderness, persistent guarding or rigidity, and evidence suggestive of ileus. Tenderness which appeared to recede in concentric areas around the site of the wound was attributed to the abdominal wall wound rather than intra-abdominal injury. Of 267 patients admitted to hospital during a one-year period, 43% were subjected to immediate operation, 4.0% were initially observed and subsequently operated upon, and 53% were treated conservatively. There was no statistically significant difference between the mortality and morbidity of the early-operation and delayed-operation groups. Two deaths in the early-surgery group occurred from unrelated causes. No mortality or significant morbidity occurred in the nonoperated group. No additional hazard resulted from judicious observation and either delayed operation or conservative treatment of carefully selected patients. ◄



Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®: Glyceryl guaiacolate, 50 mg.; Dextromethorphan hydrobromide, 7.5 mg. A. H. Robins Company, Richmond, Virginia 23220

A·H·ROBINS

Keep the Intimacy of the Doctor-Patient Relationship

Each patient is special . . . each requires personalized treatment. A close, human involvement is essential in the doctor-patient relationship.

This delicate balance can be upset by someone not familiar with the ethics and dignity of the health professions. Our staff of experienced collectors use firm, yet ethical methods to collect your past due accounts. At the same time, the intimate doctor-patient relationship is preserved.

Call us today!

Associated Credit Bureaus

OF INDIANA

affiliated with

ASSOCIATED CREDIT BUREAUS OF AMERICA

Contact your local ASSOCIATED CREDIT BUREAU OF INDIANA *member*

New Blue Shield National Account ID Card

(One of a series prepared by Blue Shield)

Blue Shield's new National Account ID Card will be seen more frequently in Indiana physician's offices as more large national organizations purchase Blue Shield coverage.

This new Blue Shield identification card looks somewhat different from the type issued by the Indiana Plan. It carries the words "Blue Shield Identification Card" and "National Account" across the top.

National Account ID Cards are given to the employees of large national organizations that have purchased Blue Shield coverage under a central certification system.

The National ID Card is used in concert with central certification to preclude the necessity of re-issue of ID cards when employees move from one plan area to another.

Central certification is an administrative system devised by Blue Shield and Blue Cross to provide certain national buyers of health coverage with a uniform set of benefits and to give the providers of care a means of identifying eligible subscribers from outside the local area by contacting the local plan.

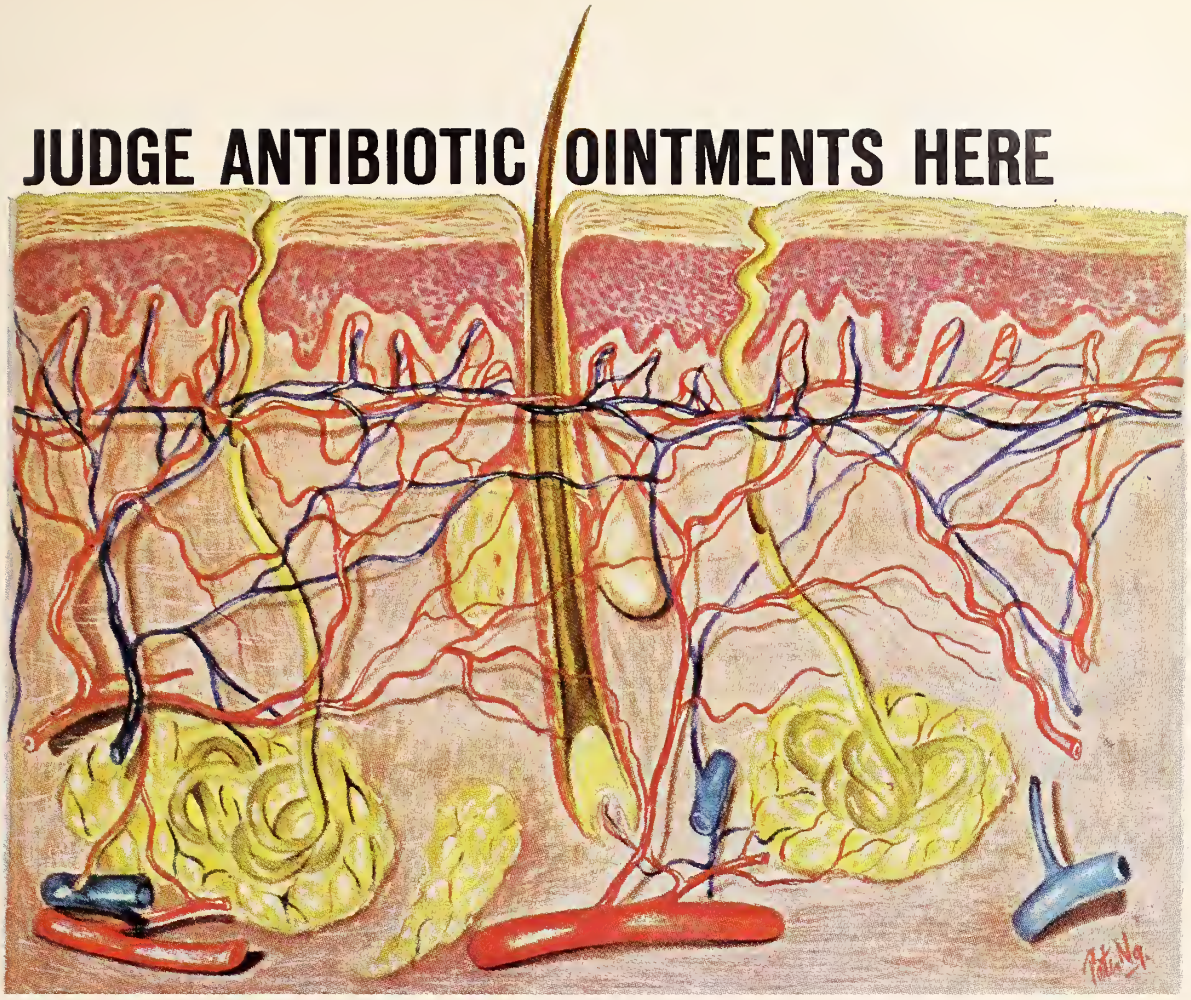
Medical and hospital benefits for employees of centrally-certified groups are uniform regardless of where the individual employee may be located.

When an Indiana physician provides professional services to a patient carrying a National Account ID Card, the medical assistant should be instructed to file the claim with Indiana Blue Shield.

This is particularly important for determining usual and customary fees for subscribers having this type of benefit program. Only the host plan can determine a proper fee allowance for services from physicians within its area. ◄

W. C. Huddlestone
Public Relations Division

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

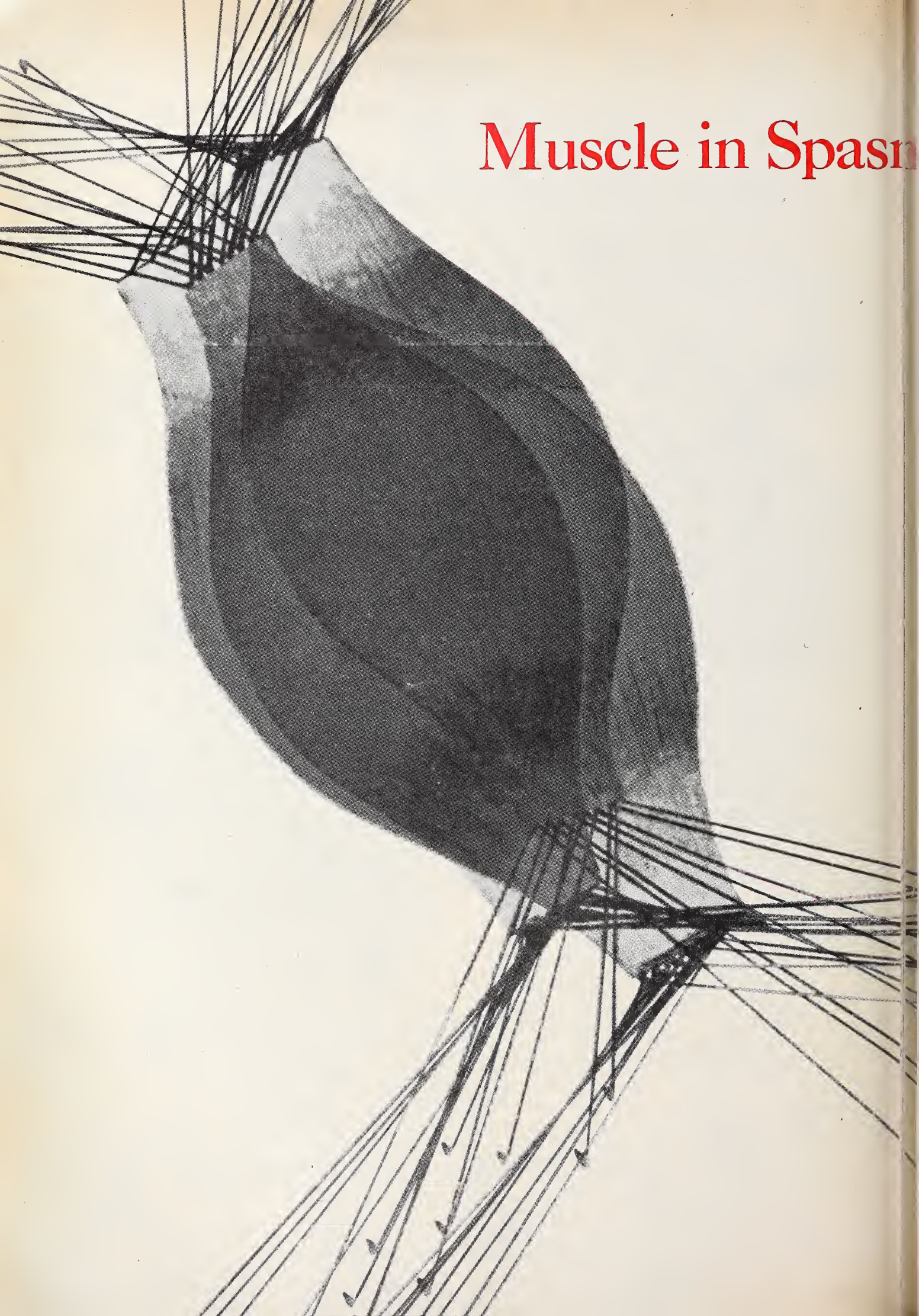
'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Muscle in Spasm



and Valium (diazepam)

The ability of Valium to help relieve skeletal muscle spasm—as well as psychic tension—demonstrates its clinical value and versatility.

The muscle-relaxant effect obtained with Valium, used adjunctively with other drugs or physiotherapy, favorably affects the entire cluster of spasm-related symptoms . . . helps accelerate return to normal activity.

When skeletal muscle spasm and psychic tension coexist, the calming effect of Valium is an added therapeutic benefit that contributes to the total management of the patient.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium® (diazepam)
2-mg, 5-mg, 10-mg tablets

ROCHE
Roche® LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Louie lost weeks with
a painful shoulder. That's a lot of fish.
It might have been different with **Butazolidin® alk**

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate
1.25 mg. homatropine methylbromide

If it doesn't work in a week, forget t.

But please don't forget this:

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alka formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Painful Shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response. (B)R 46-070-A

For complete details,
please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

8U-5926

Butazolidin® alka Geigy

Capsules
100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate
1.25 mg. homatropine methylbromide

WANTED: Physicians Locations

GENERAL PRACTICE

Charles M. Alvey, 6830 Hampton Dr., San Jose, Calif. 95120

Zakaria M. Asfoury, 33 Kasr El Nil St., Cairo, Egypt

William H. Hathaway, 710-A E. Cedar St., South Bend, Ind. 46617

John P. Kotarac, 125 Kingman Lane, Hoffman Estates, Ill. 60172

SPECIALISTS

Alejandro M. Berba, 860 Murfreesboro Rd., (A17), Nashville, Tenn. 37217—*Anesthesiology*

Raymond Joseph McGill, Johns Hopkins Hospital, Baltimore, Md. 21205—*Dermatology*

Ruben Altman, 323 Victoria St., Manassas, Va. 22110—*Internal Medicine*

William Michael Gross, 573 Race St., Denver, Colo. 80206—*Internal Medicine*

Hector Mario Echegaray, 22 Glendale Parke, Hammond, Ind. 46320—*Internal Medicine*

Everett Grahn, 1202C S. 16th St., Maywood, Ill. 60152—*Internal Medicine*

Milton Billings Good, 2140 Eldred, Lakewood, Ohio 44107—*Neurology*

T. K. Ghosh, 1 Cedar Blvd., Pittsburgh, Penn. 15228—*OB-GYN.*

M. R. Khavari, 2951 S. Parkway, Apt. #308, Chicago, Ill. 60616—*OB-GYN.*

John Leyon Branscum, 8926 Hendon Lane, Houston, Texas 77036—*Orthopedics*

James S. Close, 1004 S. DesPlaines, Forest Park, Ill. 60130—*Ophthalmology*

Robert L. Anderson, 236 Lewis, Duluth, Minn. 55803—Pathology

Jose G. Acosta-Olmeda, 613 Mountainview Ave., Syracuse, N. Y. 13224—*Pathology*

Gerald E. Fox, 2332 E. Lake Drive, Springfield, Ill. 62707—*Pathology*

Mohsen Shakerin, 55 E. Quincy Ave., Riverside, Ill. 60546—*Pathology*

Fredric Elmer Simpson, 2811 Teakwood Dr., Odessa, Texas 79760—*Pediatrics*

Joseph R. O'Connor, 2 Timber Lake Dr., Orchard Park, N.Y. 14127—*Physiatry*

Robert Hunt Hamor, 3768 N. Santom Rd., Stow, Ohio 44224—*Radiology*

Chanan W. Haenosh, % Polak, 539 E. 78th St., New York, N.Y. 10021—*General Surgery*

Richard B. Helfrick, Letterman General Hospital, San Franciso, Calif. 94129—*General Surgery*

Fredric Robert Kutner, 224-C Gray Plaza, Scott Air Force Base, Ill. 62225—*General Surgery*

James P. Durham, 15 E. Lake St., San Francisco, Calif. 94129—*General Surgery*

Gloria L. Shinn, 11311 Shaker Blvd., Cleveland, Ohio 44100—*General Surgery*

Whiber Rankin Whitsell, Jr., % James H. Pickett, Rt. 2, Box 214, Surphur, La. 70663—*General Surgery.*

ADDITIONAL LOCATIONS

Delaware—MUNCIE—population 72,000 with 130,000 in the surrounding county. Home of Ball State University with 15,000 students. Marhoefer Packing, Warner Gear and Delco Battery are major employers. Five pediatricians currently practicing. A new pediatrics wing at the local 600 bed hospital opened one year ago. There is an active intern program. All specialists are represented in the community. Association with the I.U. Medical Center, 60 miles away, is feasible. Contact L. L. Wince, M.D., Children's Clinic, 806 W. Jackson St., Muncie, Indiana 47305.

Ripley—BATESVILLE—population 5,000. 30,000 population in four communities need physicians. A 65-bed hospital with a 54-70 bed general hospital now being constructed in Batesville. One of the only alcoholic wards in the Midwest. For details contact John G. Cecil, Margaret Mary Community Hospital, Batesville 47006.

Warrick—BOONVILLE—The office and practice of the late Dr. Wendell Stover is available. Recently remodeled office located on public square in county seat town of 6,000 population. Equipment and records available. Building may be purchased or lease arranged. Contact Mrs. Wendell Stover, 20 Lakeshore Drive (phone 812-897-2481) or Don Julian, 204 S. Third St. (phone 812-897-0842)

WHITE COUNTY—Wolcott—population 1,000 with a population of 1,500 in a ten mile radius. Rich farming community. Office available. No physician in the town. Hospitals located 15 miles away at Monticello and Rensselaer and 30 miles from Lafayette, home of Purdue University, where there are two hospitals. Contact James Evans, Bank of Wolcott, Wolcott, Indiana 47995, for details.

BRACES

ARTIFICIAL LIMBS

SURGICAL APPLIANCES

CORRECTIVE SHOES

CENTRAL BRACE & LIMB CO., Inc.

1901 N. Capitol Ave.
Indianapolis, Ind. 46202
925-4296

406 S. BERKLEY RD.
Kokomo, Ind. 46901
457-4868

CERTIFIED BRACE FACILITY — MODERN PROFESSIONAL OFFICES

MEN AND LADY FITTERS

You can be there with NCME TV!

The first nationwide medical television service, NCME—The Network for Continuing Medical Education—brings you visually the important achievements of leading medical authorities. By means of closed-circuit television, this independent network provides your hospital or medical school with a complete videotape service that helps shorten the gap between new medical knowledge and its availability for clinical or teaching purposes.

NCME
The Network for Continuing Medical Education

NCME TV Offers These Practical Benefits:

☐ Every two weeks a new 60-minute videotape dealing with three separate medical subjects is sent to participating institutions.

☐ Content and format of NCME telecasts fulfill criteria for postgraduate medical education, permitting American Academy of General Practice course credits under specified conditions.

☐ To help your institution make effective use of closed-circuit television, NCME offers a wide range of services and utilization aids, including: Technical consultation in setting up a closed-circuit system; advance program information on the contents of each telecast; display units to help publicize programs; expense-paid seminars to improve utilization of medical television.

☐ NCME programs are brief and may be shown as often as desired; you can view the telecasts at times that are most convenient, without disrupting your normal schedule.

☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to NCME, 342 Madison Avenue New York, N.Y. 10017

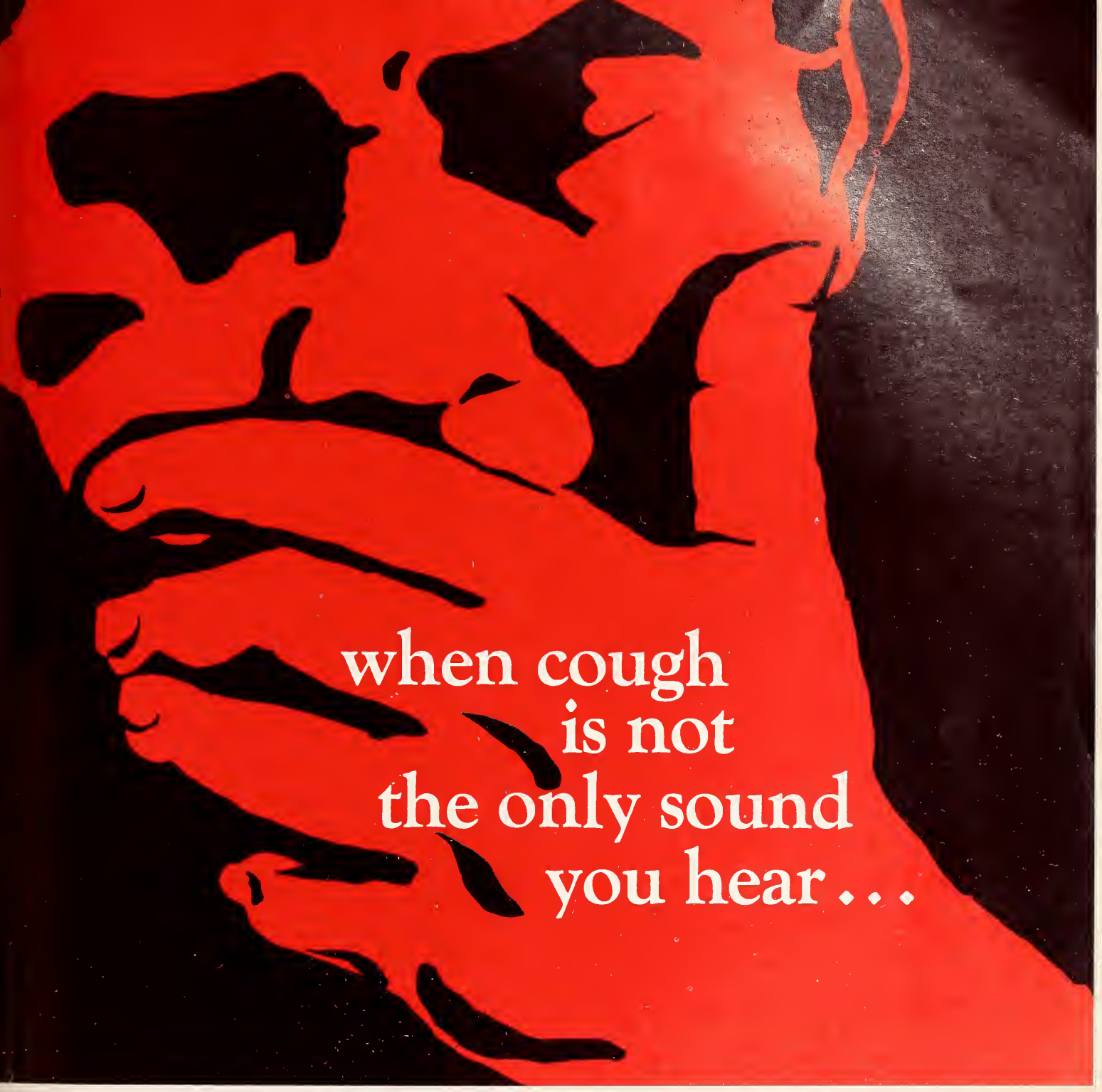
Your Contributions Are Needed . . .

SUPPORT THESE PROGRAMS OF THE AMA-ERF

- *Funds for Medical Schools* -- Contributions may be designated for one particular school. Undesignated contributions will be distributed equally among all medical schools. No restrictions are placed on the use made of this money by the schools.
- *Loan Guarantee Fund* -- Provides guaranteed loans to medical students, interns and residents. For every dollar in the fund, the private banking industry loans $12.50, at a maximum rate of 6% simple interest.
- *Honors and Scholarship Program* -- Designed to attract students of high promise to careers in medicine—meetings, personal contacts and written materials will be employed. Medical school scholarships will be available to those who need them.
- *Undesignated Contributions* -- Money not designated for any specific AMA-ERF program will be placed in the general fund and the Board of Directors will decide on its use, depending upon need.

AMA-ERF

American Medical Association
Education and Research Foundation
535 North Dearborn Street
Chicago 10, Illinois



OMNI-TUSS® b.i.d.

. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

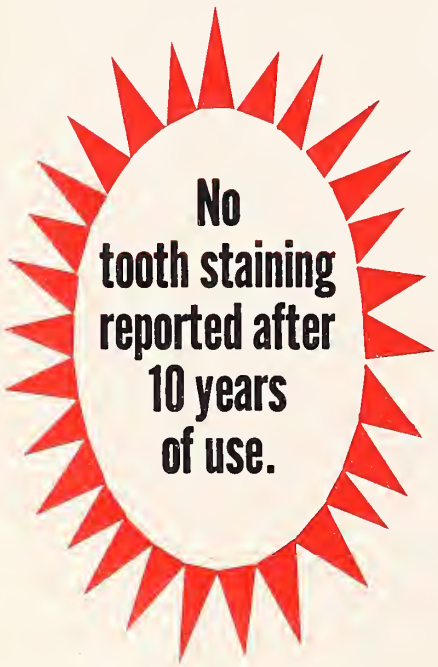
Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.

new evidence for TAO® (triacetyl-oleandomycin)



a
macrolide
antibiotic for the
frequently seen
respiratory infection
in the office
and
for a problem pathogen*
in the hospital.

*Staphylococcus aureus

study I[1]

Results of a 1967 in vitro—in vivo correlation study involving 116 patients with Gram-positive coccal infections in five institutions. All patients were given TAO prior to determining the susceptibility of the offending organism.

97.0%
of the organisms were susceptible to oleandomycin*

98.0%
of the patients responded favorably to TAO® (triacetyloleandomycin)

*In some cases more than one pathogenic organism was isolated from the patient.

study II[2]

Effect of oral therapy with TAO, erythromycin, and cloxacillin on the survival time of Rhesus monkeys after intravenous inoculations of lethal doses of staphylococci, phage type 80/81.
(8 monkeys in each group)

conclusion:

*Under the conditions of this study and the doses employed, it was found that

TAO® (triacetyl-oleandomycin)

was far superior to erythromycin, as was cloxacillin, a bactericidal agent, and of particular interest, "...bacteriostatic triacetyloleandomycin was as effective or perhaps superior to cloxacillin in preventing lethal (staphylococcal, phage type 80/81) infection."

*It should be pointed out that results obtained in an experimental study of this nature may not necessarily be directly extrapolated to the clinical situation as it pertains to man.

TAO Rx Information

INDICATIONS: Include streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents. **CONTRAINDICATIONS AND PRECAUTIONS:** Not recommended for prophylaxis or in the treatment of infectious processes which may require more than ten days continuous therapy. In view of the possible hepatoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgement dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including darkfield examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug. Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

References: 1. Isenberg, H. D.: Clinical Evaluation of Laboratory Guidance to Antibiotic Therapy; Health Laboratory Science (July) 1967. 2. Saslaw, S., Carlisle, H. N.: Studies on Therapy of Staphylococcal Infections in Monkeys. 1. Comparison of Cloxacillin, Triacetyloleandomycin and Erythromycin. Proc. Soc. Exp. Biol. & Med.: Vol. 125, No. 4 (Aug.-Sept.) 1967.

ROERIG Rx
J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017

In the complex picture of moderate to severe anxiety...

there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

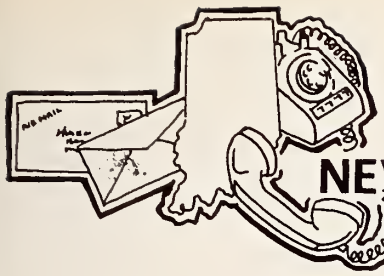
Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ

SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-16



NEWS NOTES

John Shaw Billings History of Medicine Society September Meeting

Mr. William K. Beatty, of the Archibald Church Medical Library, Northwestern University, will be the first speaker of the fall meetings of the John Shaw Billings History of Medicine Society September 11. His topic will be "Development of Medical Historiography."

Each program is preceded by a social hour and dinner on the mezzanine of the Student Union Building, Indiana University Medical Center, Indianapolis.

Dr. Baptisti Farm Group Speaker

Dr. Arthur Baptisti, Indianapolis, recently was guest speaker for the Howard County Farm Management Association. Dr. Baptisti was the first Indiana physician to serve on the hospital ship S.S. HOPE.

Dr. Dye is Speaker

Dr. Cloyd Dye, New Castle, was guest speaker recently at the District 19 meeting of the Indiana State Nurses Association. Dr. Dye told about the new coronary care unit being set up in Henry County Hospital.

Occupational Therapy Pamphlet Now Available to Physicians

"Occupational Therapy—A New Life for the Disabled" is the title of a new Public Affairs Pamphlet. It is written primarily to motivate persons who are or who may be interested in entering the occupational therapy profession.

The pamphlet is available at a cost of 25 cents from Public Affairs Committee, 381 Park Avenue South, New York City 10016.

Dr. Lukemeyer Gives Lecture

The purpose of new programs for intern and physician education was the topic of a talk by **Dr. George T. Lukemeyer,** associate dean of Indiana University's School of Medicine, at a recent meeting of the St. Joseph County Medical Society in South Bend.

Dr. Norton Appointed

Dr. Horace O. Norton, Washington, was recently appointed to the Daviess County Board of Health. Dr. Norton will fill the unexpired term of Dr. Charles Farmer, who was recently named county health officer.

Wyeth Laboratories Again Grants Residency Fellowships in Pediatrics

The Wyeth Fund for Postgraduate Education is again granting 15 two-year residency Fellowships in Pediatrics. The fund was established in 1958 by Wyeth Laboratories. This is the 11th group to be honored. Each of the 15 doctors receives a grant of $4,800 toward the expenses of advanced training.

Dr. Long Elected

Dr. Paul L. Long, Anderson, has been appointed to Anderson's Board of Health by Mayor Ed Flanagan.

Dr. Apple Honored

The Citizen of the Year Award, given by the Salem Chamber of Commerce at a recent meeting, was presented to **Dr. E. R. Apple of Salem.** Dr. Apple was chosen on the basis of his dedication to the people of Washington County and his civic work.

National Association of Foreign Medical Graduates Organized

The National Association of Foreign Medical Graduates has been organized to secure for them a hospitable atmosphere in the U.S., to aid in their assimilation, to promote interracial and intercultural relations, to discourage discriminatory practices, to enhance better understanding, to establish liaison with and to aid organized medicine, to further medical education, to adjudicate grievances against them, and to serve the sick and needy.

Antonio B. Donesa, M.D. is the Executive Secretary. The organization's headquarters is at 4023 Spanish Trail, Fort Wayne, Indiana. All foreign medical graduates who are licensed to practice medicine in the United States are eligible for membership. Unlicensed foreign medical graduates will be accepted as members of the candidate group.

Continued

Artificial Arms Return Wearer to Normal Life

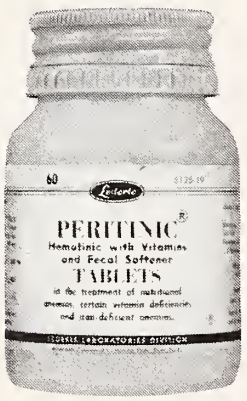
Dwight McGee of Lancaster, Ohio, wearing two Hanger Arms, can write, shave, use a knife and fork, drive an automobile, and says he can do about anything an ordinary person can do. Hanger Arms are custom-made to fit the wearer's stump and his particular daily needs, and are carefully fitted by experienced Hanger fitters. Arms can be furnished with cosmetic or mechanical hand and hook.

Hanger PROSTHETICS

1332 N. Illinois St., Indianapolis, Ind. 46202
3108 Burnet Avenue, Cincinnati, Ohio 45229
446 W. Pontiac Street, Fort Wayne, Ind. 46807
416 N. Main Street, Evansville, Indiana 47711

Continued

anticostive* hematinic



PERITINIC®

Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

* anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

488-7R—6062

MISS LUCILLE KRIBS, assistant executive secretary, retired from the headquarters office effective July 1.

A competent and efficient employee, Miss Kribs spent 40 years with the association and in 1951, on the death of Ray Smith, executive secretary, put on the entire ISMA convention.

Miss Kribs, a graduate of Indiana University, became affiliated with the association in 1928 when it was located in one small office in the Hume Mansur Building. She worked under three executive secretaries and was named assistant executive secretary in November, 1938.

Miss Kribs is an avid gardener and often brightened the headquarters office with beautiful flowers. She is also interested in travel and has plans for several trips, the first to the West in the fall.

Mrs. Frank Gastineau to Speak at Four AMA Workshops

The Woman's Auxiliary to the American Medical Association will feature four regional workshops for state presidents, presidents-elect and committee chairmen during October. The purpose of the two-day meetings is to encourage and strengthen state participation in Auxiliary projects and provide an atmosphere for an interchange of ideas among state representatives.

Main topics to be discussed include the American Medical Association Education and Research Foundation, health careers, membership, safety-disaster preparedness, community health, mental health and program development. One or two AMA field representatives will attend to discuss across-the-board AMA programs.

Mrs. Frank Gastineau, member of the board of directors, American Medical Political Action Committee, will speak at the dinner meeting at each of the four workshops. In addition, an AMA field division representative from Washington will participate in each workshop dinner session.

Following is the workshop schedule: Denver, Colo., Oct. 7-8; New Orleans, La., Oct. 10-11; St. Louis, Mo., Oct. 14-15; and Boston, Mass., Oct. 17-18.

Dr. Pippenger Honored

Dr. Wayne G. Pippenger, director of the Student Health Center and university physician at Ball State University, has been elected a Fellow of the National American College Health Association.

Continued

Diagnostic Products Sales, The Dow Chemical Company, Midland, Michigan 48640.

You won't have to wait for these results to come back from the lab. Because now you can do blood chemistry tests in your own office. With Diagnostest* reagents and instruments. You get accurate, precise results in minutes. And we teach your nurse or medical assistant to do the tests. The system can be used to measure hemoglobin, glucose, cholesterol, urea nitrogen, total bilirubin and uric acid. Write today for full details.

*Trademark of The Dow Chemical Company

DOW

NEWS NOTES

Continued

Dr. Arnholter Guest Speaker

Dr. Wynne Arnholter, Indianapolis psychologist sponsored by the Shelby County Mental Health Association, recently was guest speaker for a meeting of the Thomas A. Hendricks Parents and Teachers Association in Shelbyville. "Mature Parenthood" was the topic of Dr. Arnholter's talk.

Doctors Address Panel

Drs. Edgar L. Engel, Joseph E. Coleman, and Arnold W. Brockmole, Evansville physicians, recently discussed "Various Aspects of the Venereal Disease Problem Among Youth" during a workshop on venereal disease held at Washington School, Evansville.

Dr. Meissel Named

Dr. Robert L. Meissel, Terre Haute, has been named to the Vigo County Board of Health.

Dr. Parrot Named

Dr. Donald J. Parrot, Fort Wayne, has been named to head the Obstetrics-Gynecology Department at St. Joseph's Hospital for 1968.

New Exercise Program for Older Persons Explained in PHS Booklet

A new exercise program for older persons is explained in a new Public Health Service booklet, "The Fitness Challenge in the Later Years." It presents three levels of exercises, which permit older people to begin an exercise program at the level suited to their present physical fitness. They can then work up to longer and more strenuous exercises.

150,000 requests for the booklet were received before publication. It is for sale by the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402, at 30 cents per copy, with a 25% discount for 100 or more to a single address. Single copies may be obtained free from the Administration on Aging, Room 3339, 330 Independence Ave., S.W., Washington, D.C. 20201.

Automobile Leasing

All Types Available

12 Months or Longer

If You Want To

Know The Facts

CONSULT OUR SPECIALISTS

Phone 317-253-4415

Quality Leasing, Inc.

6310 GUILFORD AVE.
INDIANAPOLIS, IND.

Dr. Simmons is Speaker

Dr. James E. Simmons, professor and coordinator of Child Psychiatry Services at the Indiana University Medical Center in Indianapolis, recently launched a series of talks at the First United Presbyterian Church in Franklin. Dr. Simmons talk was on "Tuning In On Your Child", the importance of discipline and various techniques for disciplining children.

Dr. Bassett Honored

Thorntown Kiwanis Club members recently paid tribute to more than 20 years of dedicated medical ability and more than 50 years of hometown pride when they honored **Dr. Margaret Ann Bassett** during Recognition Night ceremonies. She was pictured as a "legend in Thorntown" and as a physician "who is always there when needed."

PHS is Establishing Two Pediatric Pulmonary Centers

The Public Health Service is establishing two pediatric pulmonary centers to improve the care of infants with pulmonary disease. Of the 93,000 babies who died in 1965, 31%, or 29,000, died of respiratory disease. Most of these deaths occurred in the first 28 days. The centers will be in Philadelphia and Los Angeles and will be managed in cooperation with university hospitals.

Dr. Love Receives Award

Dr. V. Logan Love, Fort Wayne, formerly of Marion, was recently the recipient of the Indiana Heart Association Gold Service recognition medallion for his distinguished service and leadership in the fight against heart disease.

Dr. McClure Attends Seminar

Dr. Warren McClure, Kokomo, recently attended a postgraduate seminar in Marion. Dr. McClure is vice president of the 11th District of the Indiana Academy of General Practice, which sponsored the seminar in cooperation with Eli Lilly and Company.

Dr. Hickman Named I.U.'s Assistant Dean for Student Affairs

Dr. Jack Hickman, Indianapolis, director of medical education at Marion County General Hospital since 1961, has been named assistant dean for student affairs at Indiana University School of Medicine. For the past year, Dr. Hickman has been acting as director of postgraduate education on a part-time basis. He will continue in this post.

As assistant dean for student affairs he will do counselling, work with class and organization officers, and will act as advisor to students in both academic and extracurricular activities. Dr. Hickman is a member of the Editorial Board of *The Journal.*

Continued

This isn't the end of the line.

(New TUBEX® are constantly being added)

Only TUBEX® offers so complete a line of closed system injectables

and it's still growing.

To meet your present needs more precisely, the Tubex line comprises 37 different products in 69 dosage variations. And more are on the way.

Tubex offers these unit dose advantages:

- **accuracy**—premeasured, clearly labeled to help ensure correct medication
- **convenience**—no filling, no needle-sharpening, no sterilization, no cleanup
- **simplicity**—precision-made, well balanced syringe breech loads in seconds, permits easy aspiration
- **reduces risk**—single-use cartridge-needle units reduce risk of cross contamination; less chance of spillage reduces risk of contact sensitization for doctor or nurse
- **stability**—glass cartridges can't deteriorate or react with medication
- **acceptability**—presharpened, siliconized needles lessen pain of injection; patients appreciate single-use equipment

Just select, inject, throw away

TUBEX®

Wyeth®

UNIT DOSE MEDICATION

sterile cartridge-needle unit

Wyeth Laboratories Philadelphia, Pa.

Continued

DR. IRVINE PAGE, Director Emeritus of Research of the Cleveland Clinic Foundation and onetime (1936-1945) Director of the Lilly Laboratory for Clinical Research in Indianapolis, received the $10,000 Sheen Award at the recent annual convention of the AMA. The award was established by Thomas G. Sheen in memory of his younger brother who was a physician. It was awarded for the first time this year, and will continue to be awarded "to the outstanding doctor of medical science in the United States for each year." Making the presentation was Howard F. Haneman (r), vice president of the Guarantee Bank and Trustee Company, Atlantic City, N.J., joined by Dr. David B. Allman (l), past AMA president, also of Atlantic City.

Dr. Bruner Honored

Dr. Ralph Bruner, Jeffersonville, recently was presented his 50-year Masonic pin by the Jeff Lodge No. 340 in special ceremonies exactly 50 years to the day that he joined the organization. Dr. Bruner has been practicing in Jeffersonville for 44 years.

Dr. Shuck Speaker

Dr. William Shuck, Madison, was recently the guest speaker for a meeting of the Grant County Registered Nurses' Society held at Marion. "Chest Disease" was the topic discussed by Dr. Shuck.

Five Medical Movies Available From AMA on Management of Cancer

Current concepts on the management of cancer are covered in five medical movies prepared at meetings of the American Radium Society. Cancers of the cervix, testicle, prostate and esophagus, and solid tumors in children are the subjects. The films are 16-millimeter. Each or all of them may be obtained by physicians from the AMA film library, 535 N. Dearborn, Chicago 60610.

Dr. Hogle Speaks

Dr. Frank D. Hogle, psychiatrist at the Warsaw Mental Health Clinic, was recently speaker for a special program sponsored by the Commission on Social Concerns at the Jefferson Chapel Methodist Church, Columbia City.

Continued

When eating fads of teens or tots Lead to a sudden case of "trots"

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric*
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin, and protects intestinal mucosa

In children, Parepectolin may be used to control diarrhea promptly and prevent dehydration, until etiology has been determined. In some cases, Parepectolin may be all the therapy necessary.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) ..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified) .... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Children's Dose: One or two teaspoonfuls three times daily.

ROER

WILLIAM H. RORER, INC.
Fort Washington, Pa.

NEWS NOTES

Continued

New SAMA Executive Director

Russell Staudacher, who has served for 18 years as Executive Director of the Student American Medical Association, is retiring due to ill health and will act as consultant to several other organizations.

Charles Hewitt of Kansas City, attorney and Administrative Assistant of the American Academy of General Practice will assume the duties of Executive Director of the SAMA.

Dr. Anderson Speaks

Dr. W. C. Anderson, director, Division of Chronic Disease and Tuberculosis Control, Indiana State Board of Health, recently spoke at the Johnson County Tuberculosis Association.

Dr. Miller Lectures

Dr. Albert J. Miller, pathologist of the Physicians Clinical Laboratory of Lafayette, recently presented a program to the Clinton County Registered Nurses Club at the Witham Memorial Hospital, Lebanon. Dr. Miller showed slides and lectured on "Medical Legal Autopsies."

New Publication of National Fire Protection Association

"Tentative Safety Standard for Hospital Laboratories" is the title of a publication of the National Fire Protection Association. Laboratories with flammable and explosive materials are a high-risk area in the hospital. The standards outlined are tentative. Comments are invited. Comments should reach NFPA prior to September 15 to be considered prior to development of the official regulations. Copies of "Tentative Safety etc." are available at $1.00 from the NFPA, 60 Batterymach St., Boston 02110.

Dr. Wright Gives Talk

Dr. J. William Wright, Indianapolis, spoke at a recent meeting of the auxiliary to Community Hospital. Dr. Wright showed slides of equipment purchased with proceeds from a benefit given by the auxiliary to set up the anatomical laboratory in connection with the work of the Wright Institute of Otology.

Dr. Crockett Appointed

Dr. Wayne A. Crockett has been appointed a member of the Board of Overseers of the Sheldon Swope Art gallery in Terre Haute.

Dr. Viray Honored

Dr. Victoriano G. Viray, Jr., Crawfordsville, was recently inducted into the American College of Surgeons at Chicago. Induction follows fulfilling requirements of advanced training as specialists and giving evidence of good moral character and ethical practice.

Dr. Snodgrass Speaker

Dr. Robert E. Snodgrass, Indianapolis, spoke at a recent meeting of the Southwest Parent-Teacher Organization on "Religion and Psychiatry." ◄

INDIANA BRACE, INC.

(Phone 923-2351)

Certified Orthotists & Facility

1815 N. Capitol Ave., Suite G01, Indianapolis

Free Parking

CAMP Surgical Supports SPENCER

SABEL Orthopedic Shoes

Orthopedic Braces

LAFAYETTE, INDIANA

16 N. Earl - Mar Jean Village

(Phone 447-9131)

AMA
22ND CLINICAL CONVENTION
MIAMI BEACH
DECEMBER 1-4, 1968 · CONVENTION HALL

. . . the American "Riviera." Where glittering luxury hotels tower above glamorous Collins Avenue; and medicine, sea and sunshine mix in a delightful subtropical setting.

Register now, and be on hand for the world's largest winter medical meeting—the AMA's 22nd Clinical Convention. At this midwinter "summer" session in medicine there will be Three Postgraduate Courses: Fluid and Electrolyte Balance, Diabetes, and Hyperthyroidism in the Elderly Patient • 17 Scientific Sessions • Breakfast Roundtable Conferences • Color Television • and Medical Motion Pictures. The modern, air-conditioned Convention Hall will house hundreds of scientific and industrial exhibits to show you the very latest in equipment, services and drugs.

Plan now to join your colleagues in Miami Beach. Be sure to look for the complete scientific program, plus forms for advance registration and hotel accommodations in the October 21st issue of JAMA.

INDIANA STATE BOARD OF HEALTH

MONTHY REPORT—July, 1968

Disease	July 1968	June 1968	May 1968	July 1967	July 1966
Animal Bites	1220	1505	1168	1245	967
Chickenpox	49	185	482	49	75
Conjunctivitis	103	85	116	98	85
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	7	1	12	26	44
Gonorrhea	521	593	465	425	338
Impetigo	108	100	62	116	130
Infectious Hepatitis	47	56	54	23	30
Infectious Mononucleosis	25	53	221	33	45
Influenza	78	189	444	27	112
Measles					
Rubeola	22	69	143	21	220
Rubella	27	63	203	34	102
Meningitis, Meningococcal	0	8	2	1	1
Meningitis, Other	2	9	6	7	4
Mumps	100	234	701	261	81
Pertussis (whooping cough)	15	32	33	54	32
Pneumonia	126	180	166	109	153
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	311	458	629	220	238
Syphilis					
Primary & Secondary	20	25	38	13	9
All Other Syphilis	58	142	124	74	86
Tinea Capitis	8	13	6	6	5
Tuberculosis (Active)	83	128	89	70	83

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

INDIANAPOLIS OFFICE:

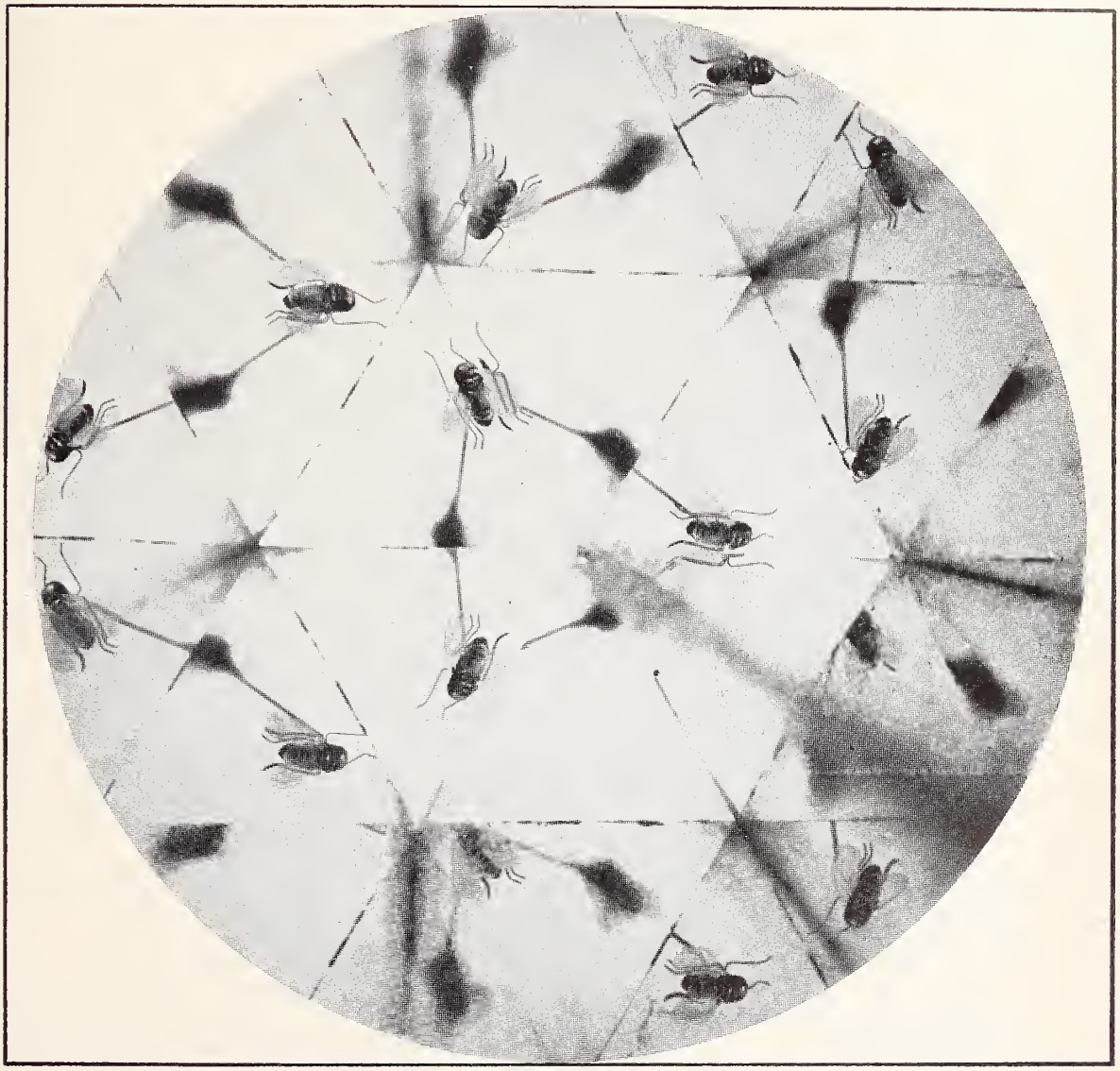
Kenneth W. Moeller and Phillip P. Capasso, Representatives

665 East 61st Street Telephone: (Area Code 317) 255-6525

Mailing Address: P.O. Box 20132, Indianapolis 46220

Why has not man a microscopic eye? For this plain reason: man is not a fly.

Alexander Pope: *An Essay on Man (1732)*



A fly takes *the narrow view* In its microcosmic universe, a grain of salt is a massive crystalline block. A blob of candy on a mole hill is a banquet on a mountain top. But man sees things *in broader perspective.* Unburdened by the finite, he projects himself among the stars . . . and through the boundless vision of his mind's eye, infinity unfolds before him. We at White-Haines take *the broad view* in meeting your professional requirements. Across the wide spectrum of our services, we provide high-quality RX service, instruments and office equipment which, in your hands, give humanity *a new outlook* on life. We supply *everything but the patient.*

THE WHITE-HAINES OPTICAL COMPANY

Headquarters: Columbus, Ohio

Serving Ohio • Michigan • Pennsylvania • West Virginia • Kentucky • Indiana • Illinois • Maryland

FUTURE MEETINGS, SEMINARS, COURSES

Work Problems of Cardiacs to be Explored at Three-Day Meeting

The work problems of cardiacs will be explored by experts in the three-day "National Conference on Stress, Strain and Heart Disease—Implications for Employee, Employer and the Public" to be held on October 10 to 12 at the Pick-Congress Hotel, Chicago.

The American Heart Association is sponsoring the meeting. In order to achieve an adequate balance of all interested groups applications are being taken for invitations to attend. Write John A. Hagan, Director of Rehabilitation, American Heart Association, 44 E. 23rd St.. New York City 10010.

Pediatric Endocrinology and Metabolic Disorders Seminar

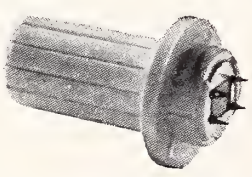
A seminar on Pediatric Endocrinology and Metabolic Disorders will be conducted by the Pediatric Section of the Methodist Hospital, Indianapolis, on Sunday, November 17.

Guest discussants will be: Richard Dexter, M.D., Assistant Professor of Medicine, Indiana University School of Medicine; Orville Green, M.D., Head, Division of Endocrinology, Children's Memorial Hospital, Chicago; and William Segar, M.D., Section of Pediatrics, Mayo Clinic. Registration will be limited. Early registration is requested. Write Gabriel J. Rosenberg, M.D., Methodist Hospital, Indianapolis 46202.

Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?
or

HISTO?

(Histoplasmosis—"The Masquerader")



A new aid in differential diagnosis

HISTOPLASMIN, TINE TEST
(Rosenthal)

The LEDERTINE™ Applicator with the Blue Handle

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle

Ask your representative for details or write Medical Advisory Dept., Lederle Laboratories, Pearl River, New York 10965. 406-8

Pan-Pacific Surgical Association 11th Congress Will be in Honolulu

The Pan-Pacific Surgical Association will hold its 11th Congress in Honolulu from October 14 to 22, following the meeting of the American College of Surgeons in San Francisco on October 6 to 10.

The scientific program will consist of some 350 speakers in all surgical specialties. All scientific meetings will be held in the mornings; afternoons will be free for sightseeing and social events.

University of Chicago "Frontiers of Medicine" Series

The University of Chicago will continue its "Frontiers of Medicine" in the academic year 1968-69. The programs will be conducted on the second Wednesday of each month from October through May. The fee for the course is $75.00; for individual session is $15.00.

The program is acceptable for 25 prescribed hours by the American Academy of General Practice. The instruction is presented by members of the faculty from 2 to 5 p.m.

Subjects for October are—"Drugs of Abuse"; November—"Current Concepts in Pediatric Surgery"; December — "Malabsorption Problems"; January—"Thyroid Disease"; February—"Diagnosis and Management of Respiratory Insufficiency"; March—"The Acute Abdomen"; April—"Pathogenesis, Diagnosis and Treatment of Rheumatoid Arthritis"; May—"Management of the Patient with Acute Myocardial Infarction." Write Frontiers of Medicine, The University of Chicago, 950 E. 59th St., Chicago 60637.

Postgraduate Course for Emergency Room Nurses

Emergency room nurses may attend a postgraduate course in Chicago on October 3, 4 and 5. A comprehensive program of instruction on all phases of emergency room work will be presented under the sponsorship of the Chicago Committee on Trauma of the American College of Surgeons.

The course will be conducted in the John B. Murphy Memorial Auditorium, 50 E. Erie St. For more information write Dr. George T. Anast, 55 E. Washington St., Chicago 60602.

Mayo Clinic Again Presents Clinical Reviews

The Mayo Clinic is presenting again this year the popular Clinical Reviews. Identical programs will be presented on two occasions to accommodate as many doctors as possible. The dates are October 28, 29 and 30 and again on November 11, 12 and 13.

The program is acceptable for credit by the American Academy of General Practice. The registration fee is $20. The audience is limited. A place with either course may be reserved by writing M. G. Brataas, Mayo Clinic, Rochester, Minnesota 55901.

Annual Radiotherapy Symposium Set for January 23-25, 1969

The Third Annual Radiotherapy Symposium of the University of Miami School of Medicine will be held January 23-25, 1969, at the Sheraton-Four Ambassadors Hotel, Miami, Florida. This postgraduate seminar will be co-sponsored by Dr. Victor Politano, Professor and Chief of the Division of Urology. Basic theme will be diagnosis and management of genitourinary tumors, including pediatric GU tumors. Included in the subjects to be covered are 1) carcinoma of the urinary kidney, 2) advances in treatment of the urinary bladder, 3) consideration of preoperative irradiation of cancer of the prostate, and 4) management of GU tumors in infants.

An outstanding faculty has been assembled, and numerous unpublished papers will be presented. Emphasis, however, will be on panel discussions and question-and-answer periods.

For additional information write to Mario Vuksanovic, M.D., Director, Radiation Therapy Division, Jackson Memorial Hospital, 1700 N.W. 10th Avenue, Miami, Florida 33136.

Tenth Medical Seminar Cruise Reservations Now Being Accepted

The Department of Postgraduate Medicine of Albany Medical College announces that reservations are now being accepted for the Tenth Medical Seminar Cruise, January 6-23, 1969.

The 17-day cruise from New York will be aboard the luxurious and distinguished ship "Gripsholm" of the Swedish American Line. Ports of call include St. Croix, Martinique, St. Vincent, Barbados, Grenada, Trinidad. LaGuaira, Venezuela, Curacao and Jamaica.

Faculty of Albany Medical College will present a comprehensive shipboard postgraduate program, covering subjects in medicine, surgery, pediatrics, obstetrics and gynecology.

Request has been made for continuation study credit for the members of American Academy of General Practice.

Organizational Meeting of American Academy of Clinical Toxicology

An organizational meeting of the American Academy of Clinical Toxicology is planned for October 22, 1968, at 9 a.m. at the Drake Hotel, Chicago. Applications for charter membership and further information may be obtained from Dr. Eric G. Comstock, P. O. Box 2565, Houston, Texas 77001.

One Day Seminar Planned on "Surgical Management of Chronic Arthritis"

The medical and scientific committee of the Illinois Chapter of The Arthritis Foundation will present a one day professional seminar on "Surgical Management of Chronic Arthritis" (rheumatoid arthritis — osteoarthritis — gout — pre and postoperative treatment) Friday, October 18 from 9:00 a.m. — 5:00 p.m. at the Sherman House Hotel, Chicago, Ill.

Programs and detailed information will be available later.

"Musculoskeletal Diseases for the General Physician" Course

"Musculoskeletal Diseases for the General Physician" will be the subject of a postgraduate medical course for internists, pediatricians and family physicians, at the University of Colorado School of Medicine on November 14 to 16. Get further information by writing the School at 4200 E. Ninth Ave., Denver 80220. ◄

A hospital for the diagnosis and treatment of psychiatric illness

WABASH VALLEY HOSPITAL

(a not for profit corporation)

2900 North River Road (State Road 43 north)

West Lafayette, Indiana, Phone 317-743-3841

Active Psychiatric Staff	(Phone)
W. R. VanDenBosch, M.D.	447-6404
David L. Evans, M.D.	447-9155
Joe M. Martin, M.D.	743-1809
Edgar C. Stuntz, M.D.	
Limited private practice	
John H. Wilms, M.D.	
F. H. Spurlock, M.D.	92-2441
Alfred R. Heasty, M.D.	

Robert K. Jones, Ph.D.
Clinical Psychologist

Mrs. Margaret Keedy, A.C.S.W.
Psychiatric Social Worker

Elizabeth J. Snyder, R.N.
Director of Nursing Service

James Jones, B.P.E.
Director of Activity Therapy

Donald R. Kinzer, Hospital Administrator

John Sterzer, Business Manager

Admissions are arranged through referral to any active staff psychiatrist.

All general medical and surgical specialties in the community are available through physicians on the open consulting staff.

Art, Hobby Show Planned For ISMA Fort Wayne Meeting

Space will be provided at the 1968 annual meeting of the Indiana State Medical Association, Oct. 15-18 at Fort Wayne for a Physicians Art and Hobby Show.

Members of ISMA interested in exhibiting pieces and requiring any information regarding this can contact any one of the following:

Dr. Charles P. Schneider
2211 W. Franklin St.
Evansville

Dr. Ray H. Burnikel
2709 Washington Ave.
Evansville

Dr. Truman E. Caylor
303 S. Main St.
Bluffton

Dr. Frank H. Coble
51 S. Eighth Street
Richmond

Dr. Lall G. Montgomery
Ball Memorial Hospital
Muncie

ISMA Headquarters
3935 N. Meridian
Indianapolis

It will be the responsibility of each physician to see that his work gets to the exhibition at the Ancient Accepted Scottish Rite Building. Final arrangements will be taken care of by Drs. Schneider and Burnikel, co-chairmen.

The ISMA will provide suitable display facilities, but each physician is responsible for transportation costs and any other such expense involved in entering his exhibit.

We solicit your exhibit to make this the largest and best ever this year.

Application for Space in Art and Hobby Show Exhibit

Mail to:

Dr. Charles P. Schneider
2211 W. Franklin St.
Evansville

Name_____

Address_____

City_____

Type and number of pieces to be displayed: Photography_____

Sculpture_____

Crafts_____

Painting_____

Other_____

Estimated amount of space required—lineal or square feet._____

Other information_____

ACHROMYCIN® WORKS HERE
TETRACYCLINE

American Map Co. Inc. New York, N.Y. 388

See inside fold for product summary.

Effectiveness: ACHROMYCIN Tetracycline is a crystalline broad-spectrum antibiotic which provides effective therapeutic activity against susceptible microorganisms.

Contraindication: History of hypersensitivity to tetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Some patients may develop a photodynamic reaction to natural or artificial sunlight. Those with a history of photosensitivity reactions should avoid direct exposure to sunlight while under treatment. Discontinue drug at first evidence of skin discomfort.

Precautions: Use may result in overgrowth of nonsusceptible organisms. Constant observation is essential. If new infections appear, take appropriate measures. Use of tetracycline during teeth development may cause discoloration of teeth.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity reaction, onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose-related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels have been reported following full therapeutic dosage. This symptom has disappeared rapidly when drug is discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. Tetracycline may form a stable calcium complex in bone-forming tissue. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: One Gm. per day, in 4 divided doses of 250 mg. each. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

ACHROMYCIN® WORKS HERE
TETRACYCLINE

Actually ACHROMYCIN works wherever the infection is due to an organism your lab cultures have shown to be tetracycline-sensitive. No other tetracycline—or analogue—can assure you of quicker or more effective antibiotic action. After all, isn't that what you want for your patient?

ACHROMYCIN was a pioneer in tetracycline therapy. Seventeen years of experience have shown that when the respiratory system, the genitourinary system, or the skin and soft tissue require treatment for infection probably caused by any of a number of sensitive strains, ACHROMYCIN is a wise choice for therapy while awaiting test results.

Available in 31 useful forms to meet your situational needs.

ACHROMYCIN® V
TETRACYCLINE CAPSULES

The cost differential—inconsequential

Lederle
LEDERLE LABORATORIES
A Division of
American Cyanamid Company
Pearl River, New York 10965

Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION ANNUAL CONVENTION
Date Dec. 1-4, 1968
Place Miami Beach, Fla.

RTHERN INDIANA CHIATRIC SOCIETY
Fourth Wednesday of every month, September through June
e For location and program, inquire Beatty Memorial Hospital, Westville

IANA PSYCHIATRIC SOCIETY
Second Wednesday of the month October through May, excluding December
e The Athenaeum, Indianapolis

ERICAN COLLEGE OF SURGEONS IANA CHAPTER
April 17-19, 1969
e Purdue University, West Lafayette

IE AND JOINT CLUB
October 30, 1968
e Athenaeum, Indianapolis

INDIANA ACADEMY OF GENERAL PRACTICE
Date April 15-17, 1969
Place Evansville

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
Date April 30-May 1, 1969
Place Imperial House, Columbus

INDIANA ASSOCIATION OF PATHOLOGISTS, INC.
Date December 7, 1968
Place Indianapolis Motor Speedway Motel

INDIANA CHAPTER OF AMERICAN ACADEMY OF PEDIATRICS
Date May 14-15, 1969
Place Stouffer Inn, Indianapolis

INDIANA DENTAL ASSOCIATION
Date May 10-14, 1969
Place Murat Temple and Essex House Motel, Indianapolis

INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY
Date October 9, 1968
Place Marott Hotel, Indianapolis

INDIANA PUBLIC HEALTH ASSOCIATION, INC.
Date April 22-24, 1969
Place Stouffer Inn, Indianapolis

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 15-18, 1968
Place Fort Wayne

INDIANA ROENTGEN SOCIETY
Date May 4, 1969
Place Holiday Inn, Indianapolis

INDIANA SOCIETY OF ANESTHESIOLOGISTS
Date May 24, 1969
Place Marott Hotel, Indianapolis

INDIANA STATE LICENSED PRACTICAL NURSES' ASSOCIATION, INC.
Date May 5-9, 1969
Place Robert Lee Motel, New Albany

INDIANA STATE NURSES ASSOCIATION
Date October 16-18, 1969
Place Civic Auditorium, Evansville

INDIANA MEDICAL BUREAU
816 Hume Mansur Bldg.
634-5804

A Licensed Employment Agency Specializing in Medical Personnel

Our 17th Year Of Service

Deaths

Robert B. Acker, M.D.

Dr. Robert B. Acker, orthopedic surgeon in South Bend for 44 years, died July 8 in St. Joseph's Hospital there. He was 83.

Graduated from Rush Medical College, University of Chicago, in 1912, Dr. Acker did postgraduate work in Italy, England, France and Austria. After serving as a medical officer in France during World War I, he was an assistant surgeon for the U.S. Public Health Service in New Mexico and New Orleans, La. Dr. Acker began his practice in South Bend in 1924.

Dr. Acker served as the first and last chief of staff of the Northern Indiana Children's Hospital and was in charge of the Orthopedic Clinic for Crippled Children at St. Joseph's Hospital at the time of his death. He also was one of the organizers and the first president of the Indiana State Society for Crippled Children and Adults, Inc. He was a Senior Member of ISMA, member of the 50-Year Club and the St. Joseph County Medical Society.

Charles E. Cook, M.D.

Dr. Charles E. Cook, 58, North Manchester general practitioner, died July 21 at Wesley Memorial Hospital, Chicago.

A life resident of North Manchester, Dr. Cook was graduated from the I.U. School of Medicine in 1935. He was a veteran of World War II and a member of the Wabash County Medical Society.

Robert J. Lewis, M.D.

Dr. Robert J. Lewis, Indianapolis general practitioner, died July 25 at the age of 57.

A lifelong resident of Indianapolis, Dr. Lewis was a member of the staff at Methodist Hospital and physician for Ladywood School. Graduated from the University of Arkansas in 1936, he had practiced in Indianapolis for 30 years. He was a member of the Marion County Medical Society.

William D. May, M.D.

Dr. William D. May, 58, superintendent and medical director of Silvercrest Tuberculosis Hospital at New Albany, died June 25 at his home.

Dr. May, a native of Mississippi, was graduated from the University of Tennessee School of Medicine in 1935. He had been superintendent and medical director at the hospital the last two years. He was staff physician at the hospital from 1957 to 1961, leaving there to become superintendent and medical director of the Indiana State Hospital for Chest Diseases at Rockville. He held that post until he returned to New Albany in 1966. Dr. May was a member of the Floyd County Medical Society.

Amado S. A. Mauricio, M.D.

Dr. Amado S. A. Mauricio, 38-year-old Rising Sun general practitioner and president of the Dearborn-Ohio County Medical Society, died May 30.

Graduated from the University of Santo Tomas, Manila, in 1953, Dr. Mauricio was on the staff of Margaret Mary Hospital in Batesville when he practiced there in 1963. He moved to Rising Sun in 1964 and was on the staff of the Dearborn County Hospital at Lawrenceburg.

Doris Hoffman, M.D.

Dr. Doris Hoffman, former Vincennes physician, died July 21 at the home of a son in Santa Barbara, Calif. She was 72.

Dr. Hoffman practiced in Vincennes from 1941 to 1966 and was made a life member of the Knox County Medical Society. Graduated from Cornell University Medical School in 1920, she taught and practiced medicine in Peking, China, under the auspices of the Rockefeller Foundation from 1923 to 1936. In 1966, she left her practice in Vincennes to become resident physician at the Methodist Home in Warren, then retired from that position because of illness in 1967. She was a Senior Member of ISMA and member of the 50-Year Club.

Thomas J. Senese, M.D.

Dr. Thomas J. Senese, Gary pediatrician and past president of the Gary Board of Health, died July 21 at the age of 64.

Dr. Senese, who had practiced medicine in Gary since 1930, was graduated from Loyola University School of Medicine in 1927. He was health board president about eight years, was on the staffs of St. Mary's Mercy and Methodist Hospitals in Gary and was a member of the Lake County Medical Society.

Henry G. Weiss, M.D.

Dr. Henry G. Weiss, 92-year-old general practitioner in Evansville, died June 27 there.

Graduated from St. Louis University School of Medicine in 1899, Dr. Weiss set up his practice in Perry County, later moving to Rockport, where he was elected coroner in 1904 and 1906. After serving in World War I, he returned to Evansville. He was on the staffs of Evansville's three hospitals and was the founder of the Good Samaritan Home there. Dr. Weiss had practiced medicine for 63 years before retiring at the age of 86. He was a Senior Member of ISMA, a member of the 50-Year Club and the Vanderburgh County Medical Society. ◄

September is Sight-Saving Month

The September Sight-Saving Month Campaign of the Indiana Society for the Prevention of Blindness deserves the cooperation and support of all citizens throughout the state.

A primary aim of the society's campaign is to alert the total community to the many causes of blindness *before* they strike. The society maintains that half of all blindness is preventable. This publication extends best wishes for the society's greatest success in carrying forward its noble objectives for better eye health and eye safety for all.

The Society is an affiliate of the National Society for the Prevention of Blindness, Inc., founded in 1908, the oldest voluntary health agency nationally engaged in the prevention of blindness through a comprehensive program of community services, public and professional education and research.

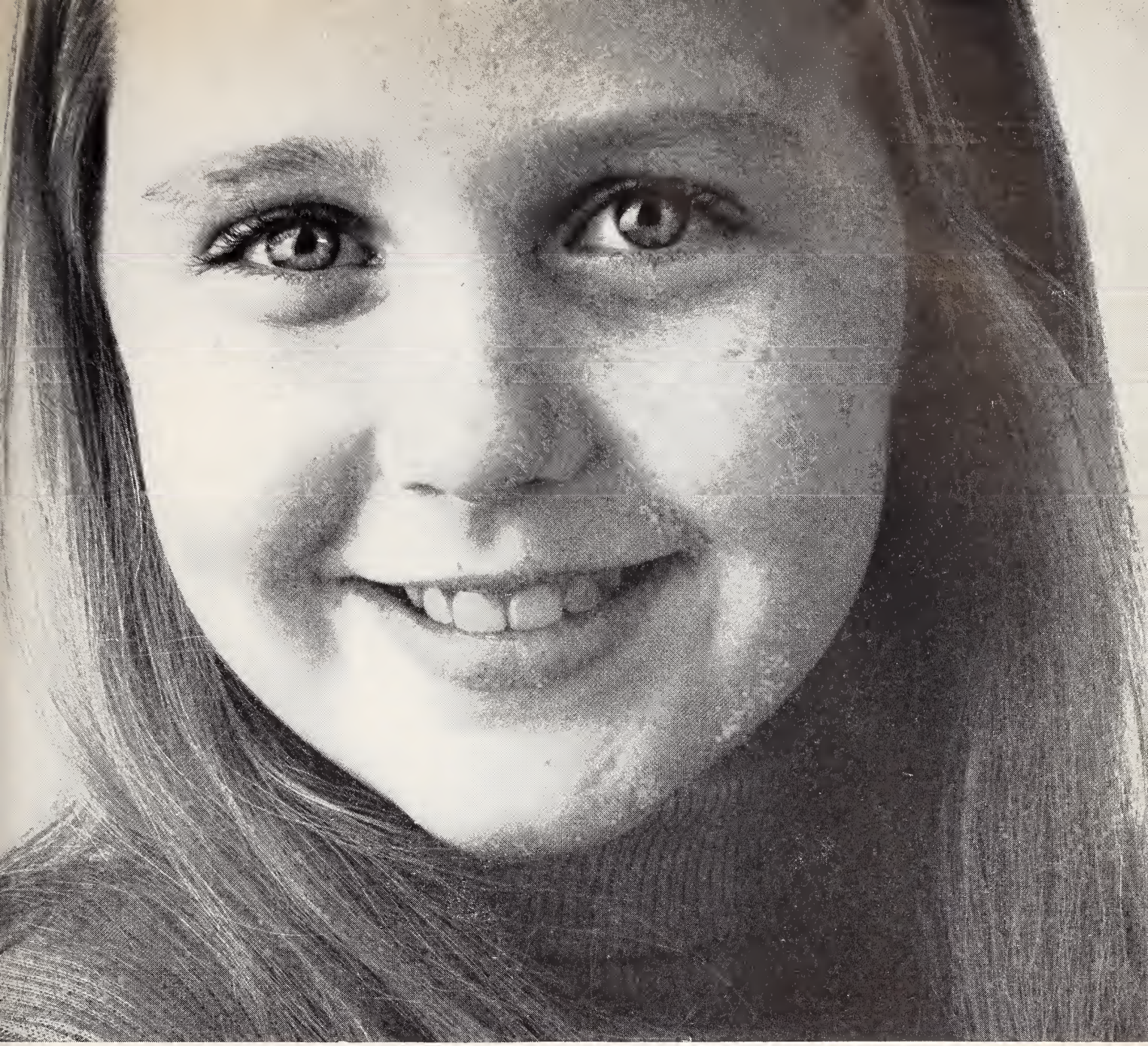


Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL PEN•VEE® K

(potassium phenoxymethyl penicillin) Wyeth®

Association News

EXECUTIVE COMMITTEE

July 20, 1968

Meeting called to order at 2:00 p.m. Saturday, July 20, 1968. In the absence of the chairman, the president, Dr. G. O. Larson, assumed the chair.

Those responding to roll call were: Burton E. Kintner, M.D., G. O. Larson, M.D., P. J. V. Corcoran, M.D., Lowell H. Steen, M.D, Lester Hoyt, M.D., Malcolm O. Scamahorn, M.D., James A. Waggener, executive secretary and Judge Ralph V. Hamill.

Minutes of the June 8, 1968 meeting were approved by consent.

Membership Report:

Full dues paying as of June 30, 1968	3,866
Interns and residents as of June 30, 1968	106
AMA full dues paying as of June 30, 1968	3,722
Full dues paying as of June 30, 1967	3,842
Interns and residents as of June 30, 1967	102

Headquarters Office

Judge Ralph Hamill presented the papers to establish Indiana Medical Foundation, Inc., and after a full discussion, the attorney was ordered to proceed with filing the foundation papers and obtaining a tax exempt status of the foundation, on motion of Drs. Steen and Kintner. A total of $106.00 was collected from those present to start the foundation.

A note of thanks from Miss Kribs was read for the retirement gift which she received from the association.

Treasurer's Report

The treasurer's report was adopted as printed.

June 30, 1968

CASH REPORT

General Fund:		
Checking	$ 5,605.76	
Savings Account	228,414.21	
Government Bonds	55,000.00	
		$289,019.97
Obligations:		
Unearned Income for Operation:		
General Fund	108,134.47	
Journal Fund	7,936.00	
A.M.E.R.F.	19,365.00	
		135,435.47
Net Cash and Investment as of 6/30/68		$153,584.50

SUMMARY OF ALL FUNDS

	Cash	Investment	Total
General Fund	$ 5,605.76	$283,414.21	$289,019.97
Journal Fund	1,044.79	—	1,044.79
Medical Defense Fund	3,431.29	25,000.00	28,431.29
Building Fund	3,132.12	25,000.00	28,132.12
Building Fund—Auxiliary Donation	—	3,863.18	3,863.18
Student Loan Fund (old)	315.00	13,781.51	14,096.51
Dues Account	8,390.12	—	8,390.12
Kitchen Fund	—	4,436.45	4,436.45
TOTAL ALL FUNDS	$21,919.08	$355,495.35	$377,414.43

Organization Matters

A request of the Student American Medical Association for use of the facilities of the headquarters building for meetings of the SAMA organization was reviewed and on motion of Drs. Steen and Kinter, the secretary was authorized to offer use of the facilities for the business meetings of this group, provided the meetings are held during a reasonable hour and if reasonable arrangements can be made.

A letter of June 13th from the chairman of the Council was read and on motion of Dr. Steen and taken by consent, a copy of the letter will be sent to the Commission on Medical Economics and Insurance and to the entire Council.

A letter of July 9th from the chairman of the Council was reviewed and by consent, it was agreed that the councilors should be invited to attend the AMA Communications Institute at association expense.

A letter from Dr. Corcoran under date of July 12 was reviewed and by consent it was agreed that Dr. Sheeley should be invited to attend the next Council meeting to give a report to the Council outlining problems and programs of his department.

A letter from J. Russell Townsend, Administrator for the Indiana Disability Program, was reviewed together with a proposal for insurance coverage of doctors falling into a substandard classification. The secretary was instructed to provide members of the committee with copies of the proposal before the next meeting of the committee.

For information, the committee was informed of a telephone call from Dr. D. D. Dickson of Greensburg concerning Medicare payments.

A letter from Blue Shield concerning the proposed amendment to the Constitution and Bylaws was reviewed for information of the committee.

Correspondence between Dr. Dwight Wilbur, President of the American Medical Association, and Dr. Bibler was read for the information of the committee.

The proposals for the establishment of Community Health Centers in Marion County was reviewed for the information of the committee.

A letter from Dr. Person, addressed to the Welfare Department in Covington, Indiana, was read and this matter is to be referred to the Commission on Governmental Medical Services for negotiation with the State Department of Public Welfare.

Letters from the Indiana Hospital Association were reviewed and on motion of Drs. Corcoran and Steen, the secretary

was authorized to attend a meeting of the Coordinated Information Project Advisory Committee to be held July 31st. Also, on motion of Drs. Corcoran and Steen, the Hospital Association is to be advised that the Indiana State Medical Association will lend their name to the support of a Regional Meeting of the Professional Hospital Activities to be held in Indianapolis on August 28, 1968.

A letter from the Community Blood Bank of Marion County, together with enclosures, was reviewed and by consent it was agreed that the Commission on Legislation should be requested to introduce a bill in the forthcoming session of the State Legislature to exempt blood as a sale.

A memo from the American College of Radiology stating that 70% of American radiologists were now billing their patients direct was reviewed for the information of the committee.

The letter recently directed by the Bureau of Motor Vehicles to physicians concerning a form to be used for examination of people for a driver's license was reviewed and the comments of Dr. Bibler objecting to portions of the form were discussed. The secretary was authorized to send this to legal counsel for a legal opinion as to the physician's liability in filling in such a form.

A bulletin from the California Medical Association concerning their Professional Liability Program was reviewed for the information of the committee.

Annual Convention, Fort Wayne, October 15-18, 1968

A review was given on plans for the meeting in Fort Wayne, with the president reporting on the visitation by himself and the secretary to the facilities which have been scheduled for the meetings of the association.

A request for a scientific exhibit by Dr. D. B. Stough was reviewed, along with Dr. Kohlstaedt's recommendation that the Executive Committee should make the decision concerning this exhibit. A letter regarding this exhibit from the Arkansas Medical Society was read. Following a full discussion, the acceptance of the exhibit was approved by consent.

Future Annual Conventions

The secretary discussed future locations for the annual meetings and reported for the 1969 meeting in Indianapolis, he has Stouffer's Inn and the Columbia Club under reservation and requested an opinion as to which location the committee felt he should use. By consent, it was agreed that the Columbia Club should be used.

For the 1970 meeting in Evansville, by consent, it was agreed that the first choice should be the Ramada Inn and the second choice the Jackson House. The choice is the new Hilton Hotel for the 1971 meeting in Indianapolis.

OCHAMPUS Matters

Several OCHAMPUS claims were then reviewed by the committee.

The Journal

The SMJAB New Report was reviewed for the information of the committee.

Future Meetings

On motion of Dr. Corcoran, and taken by consent, Mr. Bush and the field staff are authorized to attend the AMA Communications Institute.

A letter from Dr. Thomas O. Middleton concerning the request he has received from the AMA to attend a meeting on Medical Aspects of Automotive Safety in Washington, D. C., Sept. 13 and 14 was read and his attendance was approved by consent.

There being no further business, the committeee adjourned to meet again at 2:00 p.m. Saturday, August 17, 1968.

HARDING HOSPITAL, Inc.

(Formerly Harding Sanitarium)

WORTHINGTON

OHIO

For the Diagnosis and Treatment of Psychiatric Disorders

and with

Limited Facilities for the Aging

GEORGE T. HARDING, M.D.
Medical Director

DONALD L. HANSON,
Administrator

Phone: Columbus 614-885-5381

THE COUNCIL

May 18 and 19, 1968

The Council of the Indiana State Medical Association convened at 7:00 p.m., Saturday, May 18, 1968, and again at 9:00 a.m., Sunday, May 19, 1968, in the headquarters office, 3935 North Meridian Street, Indianapolis, with Dr. Lowell H. Steen, the chairman, presiding.

Roll call showed the following present:
(* Saturday night and Sunday)
(** Sunday only)

Councilors:

First District—*Gilbert M. Wilhelmus, Evansville
Second District—*Joe Dukes, Dugger
**Betty Dukes, Dugger, alternate
Third District—**Donald M. Kerr, Bedford
Fourth District—*Jack E. Shields, Brownstown, alternate (also AMA delegate)
Fifth District—**Wilbert McIntosh, Riley
*C. M. Schauwecker, Greencastle, alternate
Sixth District—*Stephen D. Smith, Knightstown
*Frank H. Green, Rushville, alternate (also AMA delegate)
Seventh District—*Albert M. Donato, Indianapolis
Eighth District—*Donald R. Taylor, Muncie
**Paul W. Sparks, Winchester, alternate
Ninth District—*Peter R. Petrich, Attica
*Clarence G. Kern, Lebanon, alternate
Tenth District—*Lowell H. Steen, Whiting
Eleventh District—*James A. Harshman, Kokomo, alternate
Twelfth District—*William R. Clark, Fort Wayne
*Frederic L. Schoen, Fort Wayne, alternate
Thirteenth District—**Otis R. Bowen, Bremen
*George B. Gattman, Elkhart, alternate

Officers:

* G. O. Larson, LaPorte, president
* Patrick J. V. Corcoran, Evansville, president-elect
* Lester H. Hoyt, Indianapolis, treasurer
** Malcolm O. Scamahorn, Pittsboro, assistant treasurer
* Frank B. Ramsey, Indianapolis, editor, *The Journal*

Executive Committee:

* Ralph V. Everly, Indianapolis, chairman
* Burton E. Kintner, Elkhart, member

Guests:

** Eugene F. Senseny, Fort Wayne, AMA delegate
* Frank H. Green, Rushville, AMA delegate
* Guy A. Owsley, Hartford City, AMA delegate
* Jack E. Shields, Brownstown, AMA delegate
* Robert M. Brown, Marion, AMA alternate delegate
* Kenneth O. Neumann, Lafayette, AMA alternate delegate
* Maurice E. Gloek, Fort Wayne, AMA alternate delegate
** George T. Lukemeyer, Indianapolis, associate dean, I.U. School of Medicine
** Glen V. Ryan, Indianapolis, chairman, Blue Shield Board of Directors
** Charles H. Aust, Fort Wayne, chairman, Convention Arrangements Commission
** Norman R. Booher, Indianapolis, chairman, Commission on Voluntary Health Agencies
** Merritt O. Alcorn, Madison, president, State Board of Medical Registration and Examination
** Marvin E. Priddy, chairman, Commission on Special Activities
** James H. Gosman, Indianapolis

Staff:

* Robert Robinson, attorney
* Robert J. Amick, field secretary
* Howard Grindstaff, field secretary
* Kenneth W. Bush, administrative assistant
* J. A. Waggener, executive secretary

The following were absent:

Councilors:

Fourth District—Robert M. Reid, Columbus
Eleventh District—Lowell J. Hillis, Logansport

Alternate Councilors:

Third District—E. L. Wallace, New Albany
Seventh District—John O. Butler, Indianapolis
Tenth District—Herman Wing, Gary

On motion of Drs. Taylor and Kerr, minutes of the meeting of March 8, 1968, were approved as editorially corrected by the chairman of the Council.

Study of AMA Delegates' Handbook

In line with the policy recently established by the Executive Committee whereby the members of the Council are responsible for matters relating to AMA policy and the AMA delegation is responsible for political and practical matters relating to the AMA, such as appointments, etc., **by consent the chairman of the Council assigned to each councilor for study 20 pages of the AMA Delegates Handbook. If, when the Handbook is received, it is in excess of 260 pages, each member of the Executive Committee is to peruse 20 pages.** Reports on this study of the contents of the Handbook are to be made at the June meeting of the Council, preceding the AMA meeting in San Francisco.

Reports of Councilors

The councilors reported on the district meetings that had been held during April and May, 1968, and announced the dates and places of the respective district meetings which are scheduled during the remainder of 1968. (Listed on page 1192 of *The Journal*).

DR. JACK E. SHIELDS, alternate councilor, Fourth District, gave the district report. Dr. Reid was reelected councilor for the three-year term beginning October, 1968. To implement communications between the members of the district and the councilor, the district society voted to increase annual district dues to $10.00 and to employ a part-time secretary to the councilor of the district. The district society also voted approval of accepting funds from Blue Shield to enhance the field departments of the state medical association.

DR. ALBERT M. DONATO, Seventh District, reported that Dr. James H. Gosman, Indianapolis, was elected councilor of the district at the May 15 meeting at Franklin. He will take office in October, 1968.

DR. WILLIAM R. CLARK, Twelfth District, reported that he and Dr. Schoen, alternate councilor, were in the process of reorganizing the Twelfth District into a representative group from each of the counties in the district, to assist the councilor and the alternate councilor in making decisions that are presented to the ISMA Council. The constitution of the district society will be rewritten, and district dues will be increased considerably, to implement the duties of the councilor and to make the district more effective in medical affairs in the State of Indiana.

Unfinished Business

1. *Better professional relations with allied groups.* Action on the recommendation of the Commission on Public Information that the membership of allied medical organizations be invited to the ISMA annual convention each year was deferred at the March 8, 1968 meeting of the Council.

Following discussion by Drs. Dukes, Taylor, Steen, Donato and Schoen, on motion of Drs. Kerr and Wilhelmus

the Council approved in principle of extending an invitation to the state medical association annual convention to paramedical and other ancillary groups. Dr. Schoen commented that "basically the purpose behind this is better public relations, better public information. We have had criticism from various groups that they were not invited, and not allowed to attend our scientific meetings."

It was agreed that the groups to be invited should include: Indiana State Dental Association, Indiana Veterinarian Association, Indiana State Nurses Association, Indiana Hospital Association, Indiana State Association of Physical Therapists and Laboratory Technicians, Indiana Pharmaceutical Association, Indiana State Association of Medical Assistants and all allied medical organizations.

2. *Health educational material.* Action on the request of the Commission on Public Information for a budget of $300.00 with which to purchase pamphlets on health subjects to fill orders for such material from high schools and various other groups, was deferred at the March 8, 1968 Council meeting.

On motion of Drs. Kerr and Clark, the Council appropriated $300.00 in the budget for the acquisition of literature on health matters, to be dispensed to those requesting it of the state medical association.

3. *Free-circulation medical journals.* As instructed by the Council at the March 8, 1968, meeting, Dr. Wilhelmus prepared the following resolution:

WHEREAS free-circulation medical magazines such as *Medical Economics* are most informative and useful publications devoted to the interests of the medical profession and we wish to commend the publishers for making them available to physicians. We have found that results of surveys of physicians fees throughout the country and certain subjects of the financial aspects of medical practice are sometimes not entirely accurate and are misleading, and

WHEREAS free-circulation medical magazines are often quoted as a source of information by the various news media and such information is given nationwide publicity far beyond what we believe is the intent and purpose of the publishers, despite the fact that they are said to be circulated only to physicians with the avowed purpose of providing information solely to members of the medical profession, and

WHEREAS sometimes misleading and inaccurate information which finds its way to the public news media often causes misunderstanding by the public, embarrassment and damage to the medical profession,

NOW THEREFORE BE IT RESOLVED **that the Indiana State Medical Association requests the American Medical Association to consult with the publishers of the free-circulation medical magazines in an effort to find a solution to this problem.**

Dr. Wilhelmus commented instead of presenting this resolution that Dr. Bibler be asked to bring this matter to the attention of the AMA Board of Trustees.

Dr. Corcoran suggested that a letter be written to the Board of Trustees rather than presenting a formal resolution which might be publicized in the papers.

On motion of Drs. Kerr and Petrich the Council voted that the president elect "compose a letter to the Board of Trustees requesting some form of inquiry and perhaps suggesting that the matters discussed in the resolution should not be freely published in the future, and embodying the sentiments expressed by the resolution submitted by Dr. Wilhelmus."

Reports of Officers

DR. G. O. LARSON, President: Mr. Chairman, members of the Council, guests: The last occasion I appeared before you I was privileged to present a number of recommendations which I understand were to be considered this evening. Tonight I will be very brief, just raise a few points.

The first thing I want to do is to thank every member of this Council, every member in this room who was present and who participated in the recent conference of County Medical Society officers. You have heard the comments of your chairman and the comments of Bob Amick. In my opinion a meeting such as this is a splendid thing. I think it accomplished a great deal and it is my hope that your future officers will continue to sponsor such a meeting.

The second point I want to make is this. I've been quite concerned since attending the Junior-Senior day at the Medical School with the attitude of the medical students toward the State Medical Association and the American Medical Association toward organized medicine. I've given this a good deal of thought and I think perhaps it's time to have a meeting of the liaison committee with the Medical School and the Council Committee and to discuss with the Dean several questions. I imagine most of you, probably all of you, have read this last issue of *P. R. Doctor.* Probably some of you, if not all of you, have read what went on in the proceedings of the Student American Medical Association convention out on the west coast recently, where several chapters withdrew from SAMA, and I think probably all of you are aware of the fact that our State Association recently appropriated $500.00 to partially defray the expenses of the delegation from I.U. Medical School to SAMA. I realize that some of the fault may be ours in considering the poor attendance at our last Junior-Senior day. But I think probably there are other factors which may have considerable bearing on this too. I'm wondering if some of the disaffection which has been shown by college students in many of our Universities throughout the length and breadth of our land hasn't entered into this perhaps on the campus at I.U. Medical School. Therefore I'm proposing that this liaison committee meet soon to discuss this question with the Dean and a number of other questions.

The next point I want to raise is this. I want to congratulate the Commission on Future Planning for the work which they have done. I think there is a place for this commission. I think they have come up with some excellent ideas. I think also that there should be a corresponding Council commission or committee on Future Planning to consider some of the ideas which are presented by the officers and the Council. I think this commission can work together with the commission of the State Medical Association on Future Planning.

At this time I want to apologize for being unable to attend many of the district meetings. It's just a physical impossibility to be in more than one place at one time. And again I wish to raise this question with all of you councilors. It seems to me that as time goes on each year it becomes more and more important for the officers of the State Association to attend each district meeting and I would again urge you to take back to your district societies the idea that with the cooperation of our headquarters office staff the dates of our district meetings be staggered so that your officers will be enabled to attend every district meeting. At least one, if not more of the officers should attend every one of these district meetings.

On the 15th, I think there was about 5 places where I should have been. I attended the Wisconsin state meeting, and enjoyed myself very, very much. I sat between the President of the Illinois State Society and the President of the Michigan State Society. I asked both of these boys what some of their big headaches were. Interestingly enough their problems are largely the same as ours.

I just want to report to you that beginning tomorrow evening I will attend a session in French Lick lasting 4½ days. This is a meeting which is sponsored by

the Brookings Institute of New York for advanced study on methods of delivery of health care to the American people. I feel that our state association should be very honored to have one of its members chosen to attend this meeting. I have a list of material which would take me I think two months to read. This material was sent to me for careful study before the meeting. I have gone over it and I've read a great deal of it. I did want to report to you that one of our state members was honored by being asked to attend this meeting of the Brookings Institute in French Lick for the next four days.

Thank you very much.

DR. PATRICK J. V. CORCORAN, President-elect:

Mr. Chairman, members of the Council: First, I want to acknowledge that The Conference of County Medical Society officers, held in Indianapolis last March, was a really good meeting, productive and worthwhile. Retrospectively, I salute our President's good judgment in having called it. The extensive experience he has had in organized medicine pays fruitful dividends in matters like these. I think our association should consider re-establishing this as an annual event, comparable to the interim meetings that some other state associations have.

I have attended two out-of-state meetings for Dr. Larson recently. The semi-annual Kentucky meeting in Covington was good. It was devoted to socio-economic matters. Speakers included Drs. Phil Lee, Frank Land, Blair Hollingsgaard, Dick Wilbur, and others. Kentucky has an indoctrination program for new members. I brought back a copy of their program which has a standard format and is held semi-annually. Members must attend a session within the first two years or be excused by their Council. We might profit by adapting some of the features of their program.

The annual Ohio State meeting in Cincinnati was very impressive and I came away with some ideas which I hope may be helpful to us. In this connection, I am beginning to understand how much an officer of the association should get around and be exposed to other groups, especially in medicine. I was not cognizant of how useful this can be until I became personally involved.

As one result of attending two meetings of adjoining states, I now believe that we should consider some form of a regional compact with the neighboring state associations. I explored this very informally with some of the members of the Ohio Association and we agreed that we have many matters of mutual concern. As one example, the Regional Medical Programs overlap in several ways. I offer this to the Council for further consideration. I believe we will find our neighbors to be quite receptive.

I would like to report to you on the results of a questionnaire which was circulated to the members of the Vanderburgh County Medical Society at our Annual Meeting last week.

Dr. Corcoran then informally discussed in some detail the questionnaire which had as its topics: Accessibility of Health Care, Costs of Health Services, possible revision of the laws on abortion, civic relations of the county medical society, and opinions regarding the *ISMA Journal.*

I would suggest that other members of the Council might consider similar projects, at least in your home area. It's very refreshing to discover how it pleases your colleagues to ask them sincerely what they think and to show you're interested in hearing about it and could be persuaded to act in accordance. This could lead to constructive results.

Thank you, Mr. Chairman.

By consent, the chair referred the President-elect's questionnaire to the Council Committee to Study Membership Matters for possible incorporation and assimilation in the membership survey on which that committee is working.

DR. LESTER H. HOYT, treasurer, reported that as of April 30, 1968, assets in the General Fund amounted to $336,000.00, with $193,000.00 obligated. With the exception of $57,000.00 in the checking account, this money is invested and is earning interest.

Summary of all funds, as of April 30, 1968:

	Cash	*Investments*	*Total*
General Fund	$ 57,817.41	$278,414.21	$336,231.62
Journal Fund	9,423.42	—	9,423.42
Medical Defense Fund	536.29	30,000.00	30,536.29
Building Fund	4,699.20	—	4,699.20
Building Fund — Auxiliary Donation.	—	3,863.18	3,863.18
Student Loan Fund (old)	2,225.12	11,293.92	13,519.04
Dues Account	34,423.50	—	34,423.50
Kitchen Fund	—	3,359.96	3,359.96
Total all Funds	$109,124.94	$326,931.27	$436,056.21

Long-term investments are:

General Fund ...$20,000.00, maturity 1972
General Fund ... 30,000.00, maturity 1983
Medical Defense Fund ..... 30,000.00, maturity 1983

Dr. Hoyt also reported that the Executive Committee is planning on investing $25,000.00 in securities in the form of a mutual fund of some kind.

On motion of Drs. Larson and Petrich the treasurer's report was accepted.

DR. FRANK B. RAMSEY, editor of *The Journal*:

Mr. Chairman, members of the Council: I was interested in Dr. Corcoran's report on his questionnaire. The format of *The Journal* at the present time is based on results of a readership survey which was made about two and a half years ago. The specific question in this questionnaire concerned the actual content of *The Journal.* The response was that we should have more scientific material prepared by the faculty of our medical school specifically for men in general practice. Our efforts since then, of course, have been to fulfill these requests. It occurs to me that sometime within the next year or year and a half, it would be a good thing to have another readership survey.

When you talk about having more socio-economic content in *The Journal,* I don't know where you are going to procure it. As you know, everything published in *The Journal* is usually written by one of the readers, one of the doctors. It is easier for a doctor to write on scientific medical subjects than it is on anything else. If you go outside the medical profession and get true, well-researched, socio-economic material, it usually must be paid for to get the job done well. This is what limits us. I do think we should probably have another survey within the next year. One thing that I am proud of is the number of short and authoritative scientific subjects that we have been able to discover in response to the last readership survey. Most of these have been done by faculty members of our medical school. There are more of these in preparation now.

Financially, we have money in the bank. Advertising sales in 1968 have not been as good as they were in 1967. Our advertising bureau, as a whole, is running 10% below what it did in the first six months of last year. That, however, is some 25 or 30% better than we did in 1966. So it is still a very satisfactory level of business and it is in proportion or even better in some instances than many of the other medical journals. It is certainly better than most non-medical and non-profit advertising the country over. All advertising is having a tough year in 1968. The AMA is — *Medical Economics* is — everybody — and my view of it, nearly as I can tell, is that the state journals are doing as well or better than almost anyone else. While the group is down some 9 or 10%, Indiana is one of the four medical journals in our

group which is actually ahead in 1968 as compared to the same period in 1967. Our percentage ahead isn't very much, it's 3.05, but it's better today. On the whole I think the financial picture is alright.

Report of AMA delegates. The chairman of the Council announced that at a meeting of the AMA delegates prior to this Council meeting Dr. Guy A. Owsley was again elected floor leader of the Indiana AMA delegation for the forthcoming meeting in San Francisco.

DR. GUY A. OWSLEY reported that the AMA delegates, in session Saturday afternoon, May 18, 1968, had discussed the candidates for the office of AMA Board of Trustees and AMA Council on Medical Education, and also the relationship of the AMA delegates to the state medical association and to the Executive Committee and the Council. It was the consensus of the delegates (elected by the House of Delegates) that inasmuch as the policy of the association is dictated by the Council when the House of Delegates is not in session, that they would abide by whatever the Council directs regarding the resolutions which will be presented at San Francisco. It was felt, however, that political matters should be left to the discretion of the AMA delegates.

Dr. Shields asked, in view of the fact that he had been elected a delegate to the state Republican convention, which convenes on June 18, and he had been chosen to assist in Dr. Bowen's campaign for governor, that he be excused from attending the San Francisco AMA meeting and that Dr. Schuster be designated as a delegate. It was reported that Dr. Ochsner also would be unable to attend the AMA meeting. Dr. Owsley suggested that in order to have a full delegation, some of the officers who are going to San Francisco should be certified as alternate delegates.

Dr. Larson moved that Dr. Shields' request be granted. Motion seconded by Dr. Corcoran.

Dr. Petrich amended Dr. Larson's motion to include permission for the AMA alternate delegates to serve as delegates when any of the AMA delegates cannot attend the AMA meetings. The motion to amend was seconded by Dr. Wilhelmus.

It was taken by consent that the amendment and the motion be taken as one motion. The motion was then put to vote, and carried.

The chairman called for nominations from the membership of the Executive Committee to fill temporarily the vacancies left by the alternates to Dr. Shields and Dr. Ochsner.

Dr. Dukes moved that "we table this vote until tomorrow so that we can think about it." Motion seconded by Dr. Petrich.

Dr. Shields requested a roll call vote. **On a roll call vote the motion to table the vote until Sunday, May 18, was passed, 10 to 3.**

The Council, meeting as a committee of the whole (on Sunday, May 19), recommended that Dr. Lowell H. Steen, chairman of the Council, and Dr. Patrick J. V. Corcoran, president-elect, be named as alternate delegates to the AMA annual meeting in San Francisco. **Dr. Corcoran's motion that this recommendation be adopted was seconded by Drs. Taylor and Kerr, put to vote, and carried.**

Dr. Don E. Wood, Indianapolis, and Dr. Dwight W. Schuster, Indianapolis, will serve as delegates in the absence of Dr. Ochsner and Dr. Shields.

Dr. Wood's alternate will be Dr. Steen and Dr. Corcoran will serve as Dr. Schuster's alternate.

Matters Referred to Council by the Executive Committee

DR. RALPH V. EVERLY, chairman of the Executive Committee, presented the following matters:

1. *Support of Infections Control Conference.* Dr. Everly read the following letter from Dr. Thomas O. Middleton, chairman of the Commission on Public Health, which was addressed to Dr. Steen:

March 22, 1968

I am writing to you as a member of the Planning Committee for a Conference on Infections Control in Hospitals and Institutions for hospital personnel.

This Conference has been set up by the State Board of Health, primarily, as a sequel to the Conference on Infections Control in Hospitals and Institutions held in September, 1967, a copy of which is enclosed. The current Conference is being sponsored by the State Board of Health, the Department of Mental Health, the Indiana Hospital Association, the Indiana University Medical Center, and with your permission, the Indiana State Medical Association.

This Conference will be directed primarily to supervisory and administrative personnel and food services, housekeeping, laundry and some in charge of maintenance.

The program will stress the role these people play in the prevention of hospital infections and the control measures for which each is responsible in the control of various kinds of hospital associated communicable and infections disease conditions. As soon as a copy of the proposed program is available, we shall send it to you. When you have an opportunity to review the program, you will note that various physicians throughout the state are involved as program participants.

We would like for the Council to approve this as soon as possible, either by full Council meeting or by Executive Committee action. We would also like for the Council to consider the State Medical Association's participation in a similar program early this Fall, which will be directed to pharmacists, nurses and diagnostic departments, such as laboratory and x-ray, which have not been specifically included in previous conferences.

One area of consideration in both of these Conferences will be to spell out the manner in which each of these various hospital departments can relate to the Infections Control Committee of the medical staff and to provide a means of communication between these various levels of administrative responsibility.

The chairman of the Council read the program for the forthcoming conference, and **upon motion of Drs. Kerr and Donato the Council voted to endorse the conference.**

2. *ISMA sponsored programs.* The Executive Committee, at its meeting on April 7, 1968, passed the following motion:

> "Upon motion of Drs. Steen and Corcoran the Executive Committee is to recommend to the Council that any program in which the ISMA is a sponsor at least three members of the Council attend as official observers."

The chairman of the Council explained that this motion came as a result of a discussion of the Junior-Senior Day which was held on April 6 and was poorly attended.

On motion of Drs. Kerr and Larson, the Council voted that three members of the Council, or their alternates, shall be delegated to attend any program which is approved, or sponsored, or funded by the Indiana State Medical Association.

The chairman of the Council will take the responsibility of appointing and notifying the councilors who are to attend the various functions sponsored by the state medical association.

3. *Suit against Blue Cross.* The secretary reported that he had received a letter from the legal counsel stating that this suit was still pending in Hendricks Circuit Court and the association will be advised as soon as a ruling is received from the court on this issue.

Economic and Organization Matters

1. *Membership report, as of April 30, 1968, as follows, was accepted by consent:*

Full dues paying	3,822
Interns and residents	94
AMA full dues paying	3,683
Full dues paying, April 30, 1967	3,789
Interns and residents, April 30, 1967	96

2. *Request for remission of state dues.* **On motion of Drs. Taylor and Dukes the Council voted not to remit the dues of a member of the Eighth District as no hardship is involved in this case.**

3. *Group insurance programs.* Dr. Kenneth O. Neumann, member of the Commission on Medical Economics and Insurance, on behalf of the commission and the headquarters office, asked for guidance as to whether or not it is desirable or advisable that the state medical association look further into group insurance programs. "The commission has no recommendation but in view of the fact that inquiries have been directed to both the headquarters office and to the members of the commission we felt we should have your guidance.

"Is it the desire of the Council that the commission investigate the matter of excess personal liability insurance, or double-type coverage on a group basis? This is the million-dollar coverage and is approximately 25 to 30% less than an individual policy, excluding water craft and air craft.

"Should the commission explore the field of group life, health, malpractice and expansion of the disability program, including overhead expense insurance?

"And then the other factor, should the agents — and I speak particularly referring to the program that is presently in operation — be permitted to contact directly the members of the association regarding this program?"

Dr. Kerr suggested that these questions be included in the questionnaire that the Council Committee on Membership Matters is preparing for distribution to all members of the association, and the chairman of the Council instructed the executive secretary to prepare a memorandum to the chairman of the membership committee, indicating that some questions along this line should be included in the questionnaire.

On motion of Drs. Taylor and Dukes, the Council voted that "a broad type coverage insurance plan on a group basis sponsored by the state medical association should be explored."

On motion of Drs. Taylor and Harshman, the Council referred this matter to the Commission on Medical Economics and Insurance with the request that the commission make a complete study of all of the insurance programs which are in effect in the majority of the states. Any program the association might decide to offer will be made available to those members who would like to buy it, and it will enable the headquarters office to answer inquiries as to what kind of an insurance program the association has for its members.

4. *Annual Convention, Fort Wayne, October 15-18, 1968.* DR. CHARLES H. AUST, chairman, Commission on Convention Arrangements, reported on the current status of plans for the convention.

The matter of televised reporting received favorable comment from the Convention Arrangements Commission. I.U.'s three television clinics want to present some live programs from the medical center to the meeting. This would be by the regional program, primarily from Dr. Lukemeyer's office.

Dr. Glock asked for the opinion of the Council on (1) whether or not the members of the association may bring so-called influential citizens, the press, etc., to the socio-economic meeting in order to present a goodly sized crowd, or whether this meeting will be restricted to physicians and their wives; and (2), will the Thursday night meeting be a dinner meeting?

Dr. Glock suggested that the Thursday night meeting not be a dinner meeting. He also stated that the physicians of Fort Wayne would like to serve as hosts to the delegates at a dinner and cocktail hour on Tuesday night.

The chairman of the Council, in answer to point No. 1, stated that at the March 8 meeting of the Council in Washington the Council voted that the socio-economic meeting would be open to ancillary personnel such as nurses, dentists, veterinarians, medical technicians and invitees of the physicians. However, he stated, the Council "didn't make that decision, it was a recommendation—I think that's a decision for the Convention Arrangements Commission."

In answer to point No. 2, the chairman of the Council said that it is the prerogative and the privilege of the Commission on Convention Arrangements in consultation with the President, with the confirmation of the Council, to arrange the Thursday night program as they feel it will work best.

Dr. Clark, chairman of the Council Committee for Orientation of New Members, called attention to the fact that the orientation meeting, scheduled from 9:30 to 10:30 a.m. on Wednesday, October 16, might conflict with section meetings and also the TV program from I.U. Dr. Aust stated there were bound to be some conflicts, and the orientation group would be somewhat separate from other groups meeting at that same time.

Dr. Corcoran moved that "the Council reaffirm its previous opinion concerning those individuals who are to be invited and permitted to attend the 'open session' on socio-economics." (This includes nurses, veterinarians, dentists, laboratory technicians, x-ray technicians, office assistants, the allied health professions, and the legal profession.) **Motion seconded by Dr. Taylor.**

Dr. Corcoran added that he thought the socio-economic program should not be a closed meeting.

Dr. Taylor said representatives of hospital boards and trustees should be included in the list to be invited, and this amendment to the motion was accepted by Dr. Corcoran.

Dr. Glock said he felt that "we should limit the people coming to this by invitation to the allied people . . . That includes anybody not necessarily members of the allied professions but also those we might hope to influence who would be interested in this meeting."

On voting, the motion of Drs. Corcoran and Taylor was adopted.

On motion of Drs. Kerr and Smith the Council voted that admission to the socio-economic meeting shall be by ticket or invitation only.

By consent, the Woman's Auxiliary of the Twelfth District was authorized to plan whatever entertainment they wish, as long as it does not conflict with the organized activities of the ISMA Auxiliary.

Closed circuit television reporting. This matter was referred by the Council at its March 8 meeting to the Commission on Convention Arrangements with instructions that the commission consult with Televised Medicine, Inc., New York, regarding details. Also, Dr. Taylor made the request that the choice of advertisers and financial arrangements be explored, and a report be made to the Council.

Dr. Aust reported that "as far as I know, TVMI has agreed to allow the ISMA to review all of the advertisers. Also, a certain percentage of the receipts would accrue to the Indiana State Medical Association. All these matters being taken into consideration, it was the feeling of the commission that since the Council, the President, and the Executive Committee are in favor of having this, we should go along with it." Dr. Aust said when arrangements for this are finalized, a report will be made to the Council.

New Business

1. *In-hospital medical coverage, ISMA group plan with Blue Cross-Blue Shield.* This item was brought up as a result of a Blue Shield conference several weeks ago at which the query was made to the panel by a member of the Indiana State Medical Association, "Why does the group coverage with Blue Cross-Blue Shield of ISMA have such poor in-hospital medical coverage?" The query later was amplified to include some of the other things.

The chairman of the Council noted that since the Council decides what coverage in conjunction with Blue Shield is to be provided under the group plan, this matter should be discussed by the Council, and if the coverage is increased the premium will increase.

The secretary commented that at the Wisconsin State meeting several weeks ago the House of Delegates adopted a resolution directing that its Blue Shield plan continue widows and children of deceased physicians in the group program, and Wisconsin's actuary said it would make no difference in rates.

On motion of Drs. Corcoran and Larson, the Council voted that Blue Shield should be petitioned to retain widows and children of deceased physicians in the ISMA group plan.

On motion of Drs. Kerr and Dukes the matter of increasing the coverage under the Blue Cross-Blue Shield group plan for ISMA members was referred to the Commission on Medical Economics and Insurance for study and report to the Council at its next meeting.

2. *Publicity on district meetings.* Dr. Petrich and many of the councilors discussed the lack of publicity at the local level on district meetings. Dr. McIntosh suggested that an executive secretary be employed for each district, or at least one secretary for each two districts, to do publicity work, keep the minutes of all county and district meetings, and so forth. **By consent, the Council referred the thoughts of Dr. McIntosh on this subject to the Future Planning Committee for study.**

It was also taken by consent that the headquarters office shall prepare a memorandum on the subject of press releases, urging that the county societies attempt to obtain newspaper publicity on county and district meetings. The chairman of the Council commented that comprehensive health planning and the work of the Council Committee on Emergency Medical Services also offered a basis for good publicity, and he requested Mr. Bush, administrative assistant, to assist in drawing up a plan for publicizing local medical events in the various counties and districts.

3. *Dr. Larson's 13 Points.* **On motion of Drs. Dukes and Corcoran, due to the seriousness and the complexity of this matter, this was tabled until the Council can devote more time to it.** This matter is to be placed on the agenda for the meeting following the instructional meeting of the AMA delegates.

Reports of Guests

DR. GLEN V. RYAN, chairman, Blue Shield Board of Directors, reported that since the first of January, 1968, Blue Shield is paying the first $50.00 instead of the first $20.00 under the Blue Shield supplemental plan.

Dr. Ryan also reported that the association's request for $50,000.00 had been referred to the Executive Committee of Blue Shield and that committee will meet on Wednesday, June 5. Dr. Ryan invited a representative of the state medical association to attend that meeting to answer questions and to explain matters to the Executive Committee.

The chairman of the Council announced that the representation at the June 5 Blue Shield Executive Committee meeting would be left to the discretion of the president of the state medical association.

DR. MERRITT O. ALCORN, president, State Board of Medical Registration and Examination, reported that representatives of the Federation of State Licensing Boards, at a recent national meeting, had unanimously voted to adopt the National Board Licensing Examination. This was part of a move to acquire a good examination which would more adequately evaluate the foreign graduates who, in increasing numbers, are applying for American licenses. Dr. Alcorn expressed the feeling that unless the states adopt steps to insure adequate licensing procedures the federal government would assume the responsibility. He asked the Council's support in adopting the National Board Examination and the change in fees from $25 to $65 or $75 which would be necessary in accomplishing this. He said a change in the Medical Practice Act would be necessary to accomplish this and would take legislative action. **By consent the Council referred this matter to the Commission on Legislation and to the Commission on Medical Education and Licensure.**

Dr. Alcorn also spoke of his concern over the advertising being done by chiropractors. He reported that 27 investigations of chiropractors had been made by the Board where flagrant violations of advertising and ethical conduct was in evidence. One case was cited. Upon advice of the counsel of the Board it was decided to give the chiropractor another opportunity, at which time he became more flagrant in his advertising. This issue, Dr. Alcorn said, had been discussed with the state attorney general with little effect, and he further stated that the Indiana Chiropractic Association would like to have something done regarding this matter. From the present legal point of view, he said, the situation offered nothing but complete frustration.

DR. NORMAN R. BOOHER, chairman of the Commission on Voluntary Health Agencies, discussed the printing and distribution of placards listing the voluntary health agencies which had met the criteria for approval of the Indiana State Medical Association and had received the endorsement of his commission. It was the consensus of the Council that the Commission on Voluntary Health Agencies should continue with its recognition program of voluntary health agencies.

On motion of Dr. Shields, seconded by many, the county medical society secretaries are to be given a supply of placards and they, in turn, will distribute these as they are required to their county society members. It was understood that this motion included the printing of the placards and distribution of sufficient quantities to the voluntary agencies to meet their needs.

DR. MARVIN E. PRIDDY, chairman, Commission on Special Activities, reported (1) that his commission had arranged for publication of six or seven articles in the state *Journal* on blood as related to blood banks, availability of blood and usage, etc., and (2) that the commission had decided to recommend having two scientific exhibits at the ISMA Fort Wayne convention — one by the Red Cross and one by the Association of Blood Banks of Indiana, because of the great difference between these two types of blood banks.

Dr. Priddy discussed the orientation program for new members and offered the assistance of his commission in this endeavor.

Dr. Priddy asked that Dr. Larson and the Council invite Reverend Paul B. McCleave, secretary of the AMA Committee on Medicine and Religion, to attend the annual convention at Fort Wayne. **On motion of Drs. Shields and Taylor, the Council approved extending an invitation to Dr. McCleave to the state convention, to meet with the Commission on Special Activities.**

DR. GEORGE T. LUKEMEYER, Associate Dean, I.U. School of Medicine, reported for Dean Glenn W. Irwin, Jr.,

who had other commitments and was unable to be present. Dr. Lukemeyer discussed in detail the preceptorship program. Approximately 20% of the senior class is now participating in the General Practice Preceptorship Program. There are other pilot programs for medical student's education in community hospitals. Student programs in OB-GYN are available in Bluffton, Fort Wayne and Indianapolis. Special Medicine electives are available in Fort Wayne, South Bend, Bloomington and Marion, Indiana. There are statewide pilot programs in Orthopedics and Surgery. Curriculum revisions are underway and there will be increased opportunities for senior electives in the 1969-70 academic year.

Dr. Scamahorn announced that the Indiana Academy of General Practice will initiate a five-year study this year on the effect and results of the General Practice Preceptorship Program, and he should have some facts to report surely within the year.

In answer to the question, "Are there any plans for extending the continuing graduate education program?" Dr. Lukemeyer said: "We have had an increased attendance at the on-campus postgraduate courses. We have initiated some visiting faculty and joint clinic programs in South Bend, Lafayette, Bloomington, Evansville, Terre Haute and Indianapolis.

A pilot video medical education network has been established. The configuration of the live medical television networks will be determined by the teleeommunication network established by the four state universities. We anticipate expansion of the television and voice network during the coming year."

Matters from Council Committees

1. *Council Liaison Committee with Blue Shield.* DR. DONALD M. KERR, chairman, reported as follows:

a. The Council Liaison Committee met on May 18 but the Blue Shield Liaison group was not present. Dr. Kerr asked for a ruling on whose responsibility it is to notify the liaison members from Blue Shield of these meetings. **It was taken by consent that hereafter, unless otherwise specified, all members of both liaison groups, that is, Council Liaison Committee and the Blue Shield Liaison Committee, shall be notified by the ISMA headquarters office.**

b. Blue Shield officials had been notified by the State Insurance Commissioner that there are only 24 members on the Blue Shield Board at this time and there are provisions for 25 members. The Insurance Commissioner has suggested, in view of the fact that there are nineteen physicians on the Board, that it would be well to fill the twenty-fifth seat with a lay person. **By consent, the Council voted that Blue Shield should refrain from making this appointment until it is told definitely to fill this vacancy.**

c. The Liaison Committee reviewed a letter written by Dr. Ryan to a Lafayette radiologist concerning payment of the radiologist's claims, for which he is billing Blue Shield direct. If the radiologist prefers not to use any of the billing methods evolved by other radiologists, Dr. Ryan agreed to hold the claims in a separate file until such time as they can be matched with the hospital claims and then all claims will be paid at the same time. The Liaison Committee was of the opinion that it should support the stand of Dr. Ryan because it felt it is reasonable and proper.

d. The Liaison Committee had referred to it two recommendations which had been adopted by the Commission on Aging, as follows:

(1) That Blue Cross-Blue Shield send simplified, cartoon style instructions to patients in order that they might more easily understand the connection between their supplemental Blue Shield and their Medicare. Also that the Independent Insurance Agents Association of Indiana and any similar organization be contacted for whatever help they might have.

(2) That the Indiana State Medical Association assume *no* responsibility for public education on matters of Medicare or other health insurance programs; but encourage all members and member societies to cooperate in education programs according to their individual desire.

Dr. Kerr said the conclusion of his committee was that Blue Shield should be asked to attempt to devise some sort of a simplified cartoon method of better explaining the relationship between Medicare and the Blue Shield supplement.

Dr. Corcoran questioned the matter of the association assuming no responsibility for public education on matters of Medicare, saying "My impression is that we as a profession have maintained a very active educational campaign on the matter of Medicare."

On motion of Drs. Corcoran and Shields, the Council voted that this matter be referred back to the Commission on Aging before the commission submits a final report to the House of Delegates.

2. *Council Liaison Committee with Blue Cross.* DR. DONALD R. TAYLOR, chairman, reported that the five physicians who represent ISMA have been retained on the Blue Cross Board. In the reorganization Dr. Kenneth O. Neumann, a member of the Executive Committee, who has done a very commendable job, was replaced by Dr. Eugene S. Rifner. The Medical Advisory Committee to Blue Cross remains the same, with Dr. William J. Stangle as its chairman. At its April 18th meeting, the Executive Committee approved the $50,000.00 annual appropriation from Blue Cross to the Indiana Hospital Association to provide for additional field representatives for the Hospital Association to assist local communities and hospitals in the development of their health facilities planning program.

For the information of the Council, Dr. Larson read the letter which he directed to the Blue Shield Board under date of April 26, 1968, as follows:

Mutual Medical Insurance Inc.
110 N. Illinois
Indianapolis, Indiana
Dear Sirs:

With the advent of P. L. 89-749 known as the Comprehensive Health Planning Act, the medical profession and all segments of the health team are faced with many decisions which must be resolved in the coming months.

I am sure this board is well aware of many of the provisions of this law. If not, I might say that the law requires Comprehensive Health Planning and the word comprehensive is defined as, "including much; inclusive; having the power to comprehend many things; of wide mental grasp." In other words there is no facet of health, as well as the contributing factors to health, that are to be overlooked in this process. Also the federal government will change its method of distribution of public health funds and rather than giving a state a designated sum for a designated purpose, the funds will be proffered in what is known as a block grant. The expenditure of these funds for public health services will then depend upon the findings and the priorities established under the Comprehensive Health Planning.

I am sure that you can well appreciate the important role physicians must necessarily play in Comprehensive Health Planning at all levels, local, regional and state. The state advisory council has been formed, and it is now our responsibility to help form local and regional groups. We know you can also envision that the educational process to bring about a complete understanding, on the part of the physician as an individual, and his county society as a unit of the medical organization, foreshadows an intensive and expensive effort. We believe you can agree with us that physicians and medical organizations must assume the responsibility

for leadership in this endeavor, the alternative being planning by others than physicians which could well develop programs which would greatly increase the cost of health care.

We feel that Mutual Medical Insurance Inc. has a very definite stake in this program, inasmuch as you represent the doctors of Indiana in providing preplanned coverage for medical, surgical and obstetrical coverage for the people of the state. Poor planning can result in increased costs to your plan. By the same token, physicians assuming leadership can be an effective catalyst in appropriate planning which should not bring about an increase in cost to the plan.

If you can agree with us that Comprehensive Health Planning in its meaning foreshadows many medical changes, not only in the practice of medicine but in the insurance mechanism, we solicit your assistance. If the Indiana State Medical Association is going to carry on a job of education among the profession, effectively and with dispatch, it means that additional personnel must be recruited, trained and and placed in the field to assist the membership and our component organizations. The Indiana State Medical Association is not financed in such a way to make the additional expense of doing this job readily available. We understand that the Hospital Association experiences a similar problem which has been recognized by your companion plan, Blue Cross, who has allocated $50,000.00 to help finance this activity by the Hospital Association.

We therefore ask for a similar appropriation from this organization in order that we may keep face in the implementation of this program.

Sincerely yours,
G. O. LARSON, M.D., President

3. *Council Liaison Committee with I.U. School of Medicine.* DR. PETER R. PETRICH, chairman, announced that the committee is to meet with the I.U. officials prior to the next meeting of the Council and he will have a report for that meeting.

4. *Council Committee for the Study and Implementation of Governmental Medical Programs.* DR. ALBERT M. DONATO, chairman, distributed a proposed planning chart for establishing local comprehensive health planning groups and a booklet entitled, "A Look at Association Committees." He then gave a progress report on what the Committee on Governmental Medical Programs has done.

The committee has met with the executive personnel of the Indiana Hospital Association and the Indiana State Medical Association for the purpose of establishing an advisory committee to assist in the organization of local comprehensive health planning committees. Members of the committee have been active throughout the state by attendance at county meetings to aid in the organization of the comprehensive health committees. "We are considering ourselves as an advisory committee. It was decided that when requested to go out to various societies to help in organization that not only would doctors go, but also hospital people would be there. We believe this will assist in implementing healthy organization of these local committees. This little booklet that I passed out to you is something that may help you in the organization of these groups, about how committee structures should be formed, and I think it is worthwhile reading.

"We also participated in the Public Health Association meeting in Indianapolis a few weeks ago, with a group of public health officers. The reception that we got and the suggestion to include this group of people into the area of trying to implement this program was very well received."

Dr. Donato thanked the members of the Council for their excellent cooperation and the members of his committee and the Executive Committee for their assistance in organizing the program.

Dr. Larson reported that he had been named to the executive committee of a 65-member State Advisory Committee on comprehensive health planning.

5. *Council Committee for Orientation of New Members.* DR. WILLIAM R. CLARK, chairman, reported that his committee felt the indoctrination booklet which was recommended by the Commission on Special Activities and authorized by the Council, was excellent. **On motion of Dr. Clark, seconded by several, the Council approved the sending of this pamphlet to each member of the association.**

Regarding the orientation meeting, Dr. Clark presented an outline showing three courses of action:

(1) A meeting to be held in Fort Wayne on Wednesday, October 16, from 9:30 to 10:30 a.m.

(2) A program could be set up, to be held in Indianapolis at a later date, beginning at 4:00 p.m., with a social hour at 5:00 p.m. and dinner at 6:30, concluding *possibly* with a speaker.

(3) The committee recommends that the entire program be eliminated as a membership requirement. This could be done by resolution to the House of Delegates at the fall meeting.

Dr. Dukes moved that the orientation meeting be held at Fort Wayne at the allotted time, 9:30 to 10:30 a.m. Wednesday, October 16, with the format as presented by Dr. Clark, and that every effort be made to contact by special letters the new members, asking them to attend. Motion seconded by Drs. Petrich and Kerr.

Dr. Petrich moved to amend Dr. Dukes' motion to not limit the closing time, and also to refer back to Dr. Clark's committee a consideration of an alternate meeting time in April in Indianapolis, depending upon the results of the first meeting in Fort Wayne. This motion was seconded by Dr. Bowen, put to vote, and carried.

Dr. Dukes' motion, as amended, was put to vote and adopted.

6. *Council Committee to Study Membership Matters.* DR. OTIS R. BOWEN, chairman, presented the following report:

The Council Committee to Study Membership Matters met at 4:30 p.m., May 17, 1968, with Drs. Donato, Kerr, McIntosh and Bowen present.

Our Council committee was mandated by the Council, which in turn was mandated by the delegates to the ISMA, to proceed with a membership survey.

The following decisions were reached:

(1) After reviewing the Illinois State Medical Association Opinion Survey, which is about an inch thick book, a survey conducted by an opinion research company would be too expensive for the amount of information to be gained; thus, the committee, with the help of the ISMA staff, should conduct the survey.

(2) The questions submitted by the ISMA staff were reviewed and the decision was that they were appropriate; other questions to be added concerned the following subject matter:

(a) *Dues.* Are you getting your money's worth? If not, what do you suggest as to amount, and for what should the money be spent?

(b) *Services of staff and field secretaries.* Are you satisfied with their services, with frequency of visitation by field secretaries? If not, what do you suggest? If more services and more visitations are requested, would you be willing to support them financially?

(c) *Cost of medical services.* How could the people be made more aware of the amount of charity work done by physicians? How could the people be made more aware of the percent of health dollar that goes to the physician, for medicines, for hospitals? What percentage of your hospital dollar income

goes to actual labor costs?

(d) Have a blank sheet with a statement to tell them to put down their complaints and/or suggestions.

(3) It was felt that to get best response that

(a) the secretary of each county society be made responsible for getting surveys answered by the members of their respective societies.

(b) that conspicuous advertisements in *The Journal* and in the News Letter be done to encourage cooperation in answering the questionnaire.

(4) That the questionnaires be returned through the secretaries to ISMA headquarters where the results will be tabulated. The Membership Committee then will try to interpret the results and draw some conclusions.

Dr. Bowen moved that this report be accepted. Motion seconded by many.

The chairman of the Council called attention to the survey that Dr. Corcoran had conducted in Vanderburgh county, on which he had reported earlier in the meeting, and to the fact that the Council, by consent, suggested that a part or all of the questions used by Dr. Corcoran be incorporated in the survey to be made by the Membership Committee, and that the economics of this survey are to be worked out by the Membership Committee and the staff. **Dr. Bowen accepted these suggestions as a part of his motion. The motion was put to vote, and carried.**

7. *Council Committee on Business Consultants for The Journal.* DR. JOE DUKES, chairman, reported that the only item his committee had was to call attention to the fact that two new members are to be elected to the Editorial Board this fall.

Dates for Future Meetings

On motion of Drs. Petrich, Clark and Dukes, June 9, 1968, was set for the next meeting of the Council.

On motion duly made, seconded by Dr. Smith, August 18, 1968, was selected as the date for the summer Council meeting.

Child Health Law

By consent, the material on the Child Health Law was referred to the Commission on Legislation, to be reported on at the August Council meeting.

There being no further business, the meeting was adjourned.

COMMERCIAL ANNOUNCEMENTS

BUY AND TRY: Wye Plantation Aberdeen-Angus frozen semen from Advanced Register P.R.I. sires officially goining over four pounds per doy or whose 365-day weights are above 1,200 pounds. (Performonce tested sires olwoys for sale.) WYE PLANTATION, Queenstown, Maryland 21658. Telephones: 301-827-7166 or 301-827-7160.

WANTED: In a college community, an associate or partner for a large medical practice. No surgery or OB. General practice con be done if desired. X-roy and laboratory facilities in the office. If desired, will consider sole. Write Box 344, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

SURGEON, OUTSTANDING FINANCIAL OPPORTUNITY: Only one other surgeon in county of 40,000; join 54-bed hospital, lake resort area near Notre Dome University; apply American Medical Personnel, 159 E. Chicago Ave., Chicago, Illinois, Delores Susral, Director.

ANESTHESIOLOGIST: Position available for a Board Certified or eligible in a 200-bed modern, progressive general hospital in beautiful residential community. Salary dependent upon qualifications, ranging from $19,206 to $23,075. Excellent fringe benefits. Must be licensed in a state, territory, or commonwealth of the United States or in the District of Columbia. Non-discrimination in employment. Contact Chief of Staff, Veterans Administration Hospital, Fort Wayne, Indiana.

FOR SALE: The unexpected death on August 18 of Dr. Wendell Stover, Boonville, makes avoilable his proctice. Recently remodeled office located on public square in county seat town of 6,000 population. Equipment and records available. Building may be purchased or lease arranged. Contact Mrs. Wendell Stover, 20 Lakeshore Dr. (phone 812-897-2481) or Don Julian, 204 S. Third St. (phone 812-897-0842).

FOR SALE: Urological equipment: microscope; cystoscopes; urological books; Edison Voicewriter; complete urological instruments. Only interested in selling as a complete unit. Has been oppraised. Write Box 354, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

EMERGENCY ROOM PHYSICIAN: Excellent opportunity tor young physician interested in full-time proctice of emergency room care. Join a physician group responsible for the emergency service of two major Cincinnati hospitals. Remuneration on a fee-for-service bosis with guaranteed minimum. Must have or be eligible for Ohio license. Send resume to P. O. Box 36163, Cincinnati, Ohio 45236.

OPENING for pothologist, psychiatrist and generol practitioner (preferably with psychiatric or geriatric experience). 1651-bed general medical-surgical and psychiatric hospital with excellent facilities and progressive staff; an equal opportunity employer. Salary: $13,507.00 through $23,921.00 according to troining and experience. Write to Director, VAH, Danville, Illinois 61832.

WANTED: Quiet, progressive community of 7,000 in East Central Indiana needs more general practitioners. Within 25 minutes of three hospitals. Three doctors in area now. Excellent educational system. Within 1½ hours of Indianapolis, Dayton, Cincinnati. May we send you more information? Community Medical Services Council, Box 222, Cambridge City, Indiana 47327.

PSYCHIATRIC RESIDENCIES: Starting July 1969. Approved training in a mental institution with State of Michigan, Department of Mental Health. Three and five yeor progroms available. Salary $9,876-$11,233 and $11,254-$21,381. NIMH-GP stipends $12,000. Located in Michigan's serene, scenic recreation area on Grand Traverse Bay. For additional information, contact Dr. Paul Kauffman, Training Director, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

INTERNIST: Position available for a Board Certified or eligible in a 200-bed modern, progressive general hospital in beautiful residential community. Salary dependent upon qualifications, ranging from $19,206 to $23,075. Excellent fringe benefits. Must be licensed to practice in a state, territory, or commonwealth of the United States or in the District of Columbia. Non-discrimination in employment. Contact Chief of Staff, Veterons Administration Hospital, Fort Wayne, Indiana.

PEDIATRICIAN: Salary to $18,000 first year, partnership with 3 general practitioners second year. Midwest university town; 600-bed hospital; intern program. Contact L. L. Wince, M.D., Children's Clinic, 806 W. Jackson St., Muncie, Ind. 47305.

DUCK HUNTERS: I am a registered duck guide and am now offering guide service on Saginow Bay where there are more ducks, less hunters and better shooting. Decoys, blinds and tronsportotion to hunting grounds provided. If interested, please write for free pictured brochure to John Pestrue, Standish, Mich. 48658.

NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

Charges for commercial announcements are:

First four lines: $3.00
each additional line: 50¢

Send cash with order. Average count: seven words to the line.

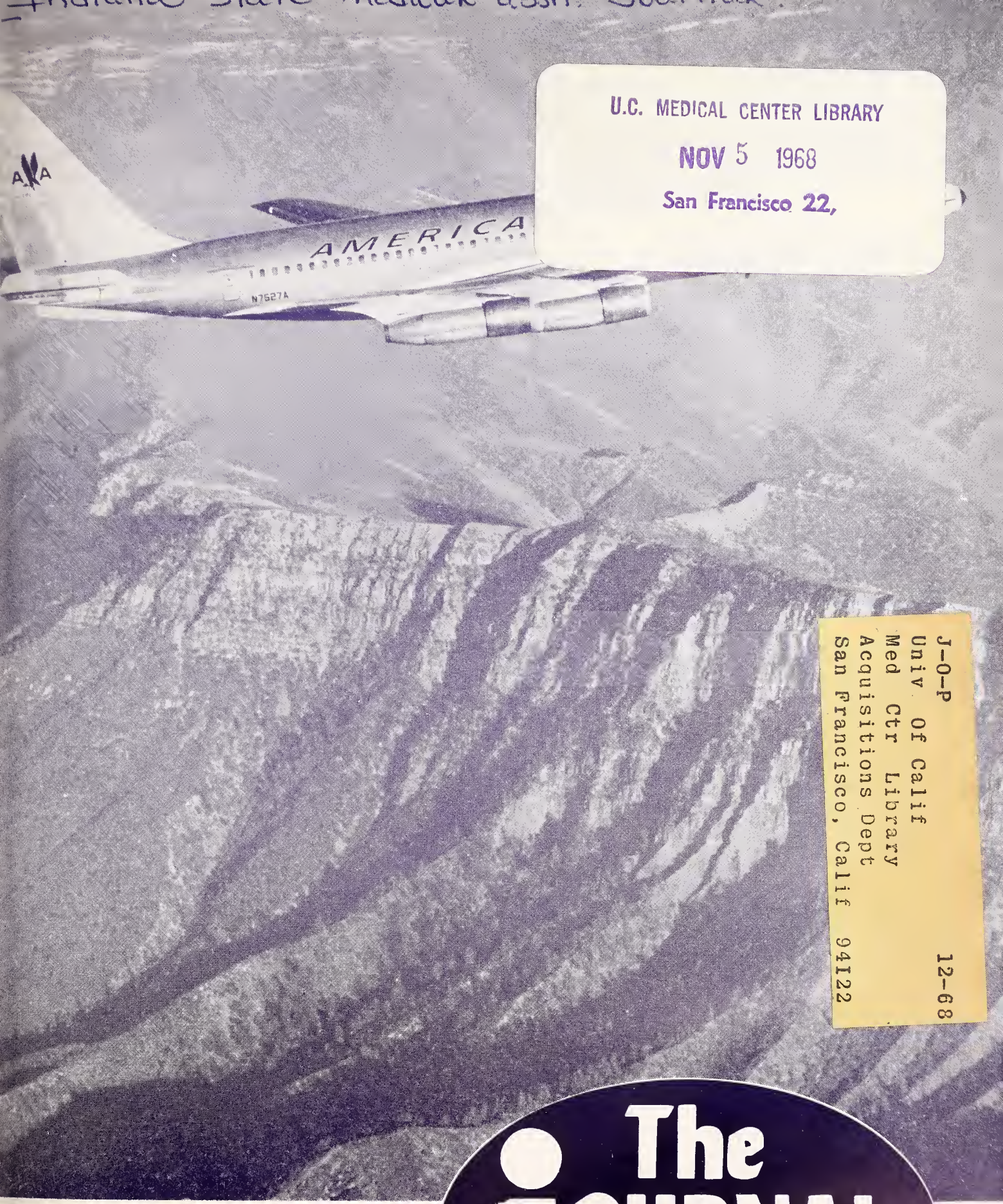
DEADLINE: Fifth day of month PRECEDING month of issue.

ADVERTISERS IN THIS ISSUE

September 1968 Volume 61 No. 9

Abbott Laboratories 1295-99
American Fletcher National Bank ....2nd Cover
Associated Credit Bureaus of Indiana 1317
Bio-Dynamics, Inc. 1301
Breon Laboratories, Inc. 1318
Brown Pharmaceutical Co. 1293
Burroughs Wellcome & Co., Inc. 1319
Campbell Soup Company 1223
Central Brace & Limb Co., Inc. 1324
Dow Chemical Company, The 1333
Geigy Pharmaceuticals 1290-91, 1322-23
Hanger, J. E., Inc. 1331
Harding Hospital 1353
Home Lawn Mineral Springs 1311
Hook's Drugs 1189
Hynson, Westcott & Dunning, Inc. 1185
Indiana Bell Telephone 1289
Indiana Brace, Inc. 1338
Indiana Medical Bureau 1349
Indiana National Bank 1229
Lederle Laboratories 1187,1210-11, 1304, 1314, 1332, 1342, 1345-48
Lilly, Eli & Company 1194-95, 1212, 1226
Medical Protective Co. of Ft. Wayne 1340
Merck, Sharp & Dohme 1191
Mutual Medical Insurance, Inc. 1313
National Drug Company 1197
Parke, Davis & Company 1303
Pitman Moore Company 1203
Poythress, Wm. P. & Co., Inc. 1312
Professional Life & Casualty Co. ....3rd Cover
Quality Leasing, Inc. 1334
Robins, A. H. Company, Inc. 1193, 1309-10, 1316
Roche Laboratories ....4th Cover, 1320-21, 1325
Roerig, J. B. & Co. 1328-29
Rorer, William H., Inc. 1209, 1337
Samaritan Foundation, Inc. 1220-21
Sandoz Pharmaceuticals 1330
Searle, G. D. & Co. 1224-25
Smith Kline & French Laboratories 1315
Strasenburgh Laboratories 1327
Stuart Company, The 1196
Wabash Valley Hospital 1343
Warner-Chilcott Laboratories 1205-06
Warren-Teed Pharmaceuticals 1198-99
White-Haines Optical Co. 1341
Wyeth Laboratories 1335-36, 1351

In accepting advertising for publication, *The Journal* has exercised reasonable precaution to insure that only reputable factual advertisements are included. However, we do not have facilities to make any comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services, and medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertiser only. Neither sanction nor endorsement of such is warranted, stated, or implied by the association.



U.C. MEDICAL CENTER LIBRARY
NOV 5 1968
San Francisco 22,

J-O-P
Univ Of Calif
Med Ctr Library
Acquisitions Dept
San Francisco, Calif 94122
12-68

The JOURNAL

OF THE INDIANA STATE MEDICAL ASSOCIATION
Indianapolis, Indiana
October, 1968 Vol. 61 • No. 10

arting this month:
New Series on
AVIATION MEDICINE

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.

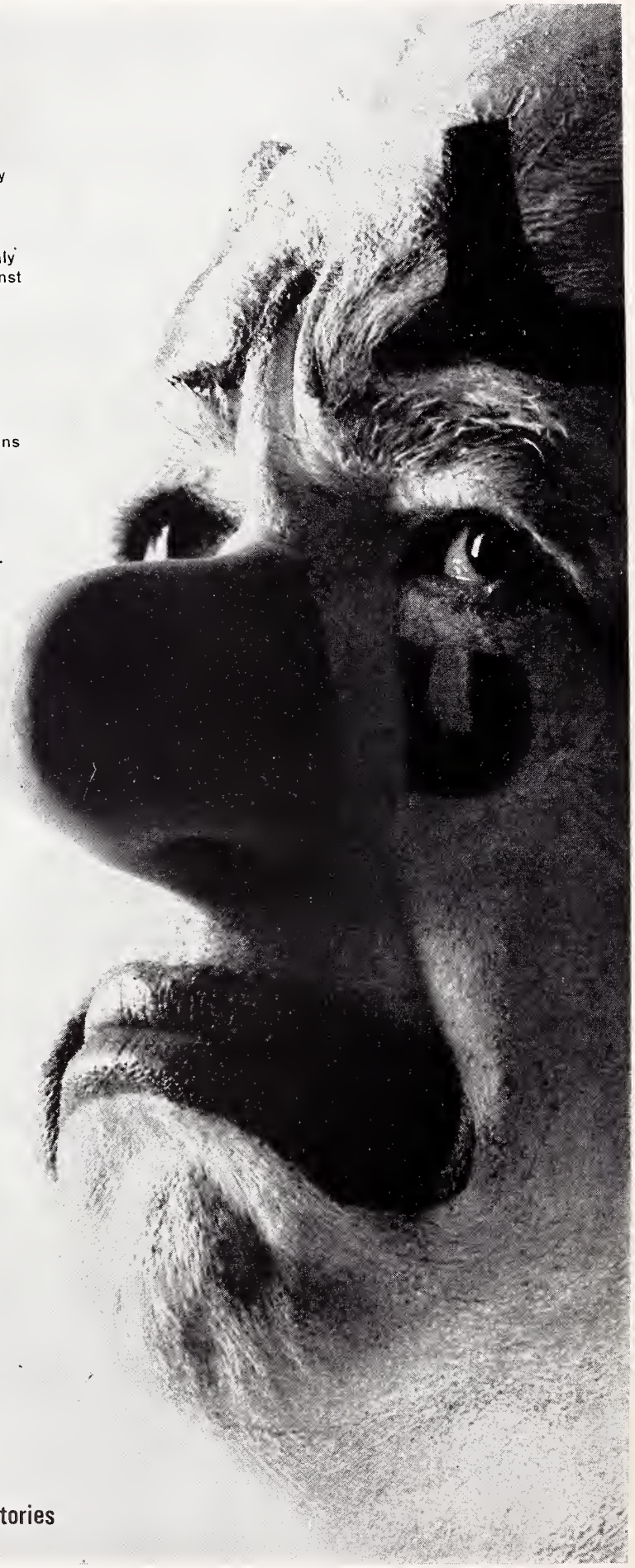
Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.

Usage in Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.

Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.

Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.

Supplied: Bottles of 50 capsules.



a stuffy nose is no laughing matter

Ornade® Trademark

Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

Spansule® Capsules

brand of sustained release capsules

each one can give him all-day or all-night relief of nasal congestion

SK&F Smith Kline & French, Laboratories

■ to help restore and stabilize the intestinal flora

■ for fever blisters and canker sores of herpetic origin

LACTINEX contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

First introduced to help restore the flora of the intestinal tract in infants and adults,[1, 2, 3, 4] LACTINEX has also been shown to be useful in the treatment of fever blisters and canker sores of herpetic origin.[5, 6, 7, 8]

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

References:

(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

HYNSON, WESTCOTT & DUNNING, INC.

BALTIMORE, MARYLAND 21201

(LX04)

LX
LX
LX

OCTOBER 1968

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Office of Publication

3935 N. Meridian, Indianapolis, Indiana 46208

Contents

SCIENTIFIC

Medical Considerations for Patients in Commercial Air Travel, Robert B. Stonehill, M.D., Raymond H. Murray, M.D., Indianapolis 1395

Arterial Lesions Due to Blunt Trauma, John L. Glover, M.D., Charles A. Waltz, M.D., Harold King, M.D., Indianapolis 1403

Treatment of the Exudative Tonsillar Phase of Infectious Mononucleosis with Oral Enzymes, Mac C. Roller, M.D., Franklin 1411

The Management of Depressive States, John I. Nurnberger, M.D., Indianapolis 1416

Clinicopathologic Conference, Roy H. Behnke, M.D., Roscoe Miller, M.D., Charles Petty, M.D., Indianapolis 1423

The Case of Sanguinous Sanctity, Arnold Lieberman, M.D., New York, N.Y. 1434

Electrocardiogram of the Month: Concealed Digitalis Toxicity, Charles Fisch, M.D., Indianapolis 1443

X-Ray Conference: Changes of the Diploic Space Secondary to Anemias Mimicking Intracranial Lesions on Technetium Scintiscanograms, Patrick E. Sewell, M.D., Erich K. Lang, M.D., Shreveport, La. 1446

Path-Finder: Pre-diabetic Glucose Tolerance Curve, H. P. Palmer, M.D., Franklin ... 1451

EDITORIALS

Army MUST System Improves 1454

22nd AMA Clinical Convention 1454

The Promised Second Misconception 1455

Are You Safe At Home? (Guest) 1455

Editorial Notes 1456

SPECIAL FEATURES

Aspirin, Jessie M. Stevenson, Indianapolis 1462

Local Board of Health Services—Today and Tomorrow, Lee J. Maris, M.D., Attica .. 1466

The Physician and the National Library of Medicine, Leonard Karel, Ph.D., Bethesda, Md. 1470

REGULAR FEATURES

What's New? 1377

Month in Washington 1380

Letters to the Editor 1384

Fourth Estate 1391

From The Journal 50 Years Ago 1398

President's Page 1458

Medical Panorama: A Separate Department of Health?, A. W. Cavins, M.D., Terre Haute 1473

News from the I.U. School of Medicine 1474

Day by Day with the F.D.A. 1475

Gleaned from the British Medical Journal, Jack W. Hickman, M.D., Indianapolis .. 1476

More Protection for Blue Shield Members (One of a Series) 1477

Wanted: Physicians, Locations 1477

Medicine At Law 1478

Abstracts, Book Reviews 1481

News Notes 1485

Annual Meeting Dates of Professional Medical and Allied Organizations 1491

Board of Health Report 1492

Future Meetings, Seminars, Courses 1493

Deaths 1495

BUSINESS

Executive Committee: August 17, 1968 1496

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 46202. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

Representative for national advertising is the State Medical Journal Advertising Bureau, 510 N. Dearborn St., Chicago, Ill.

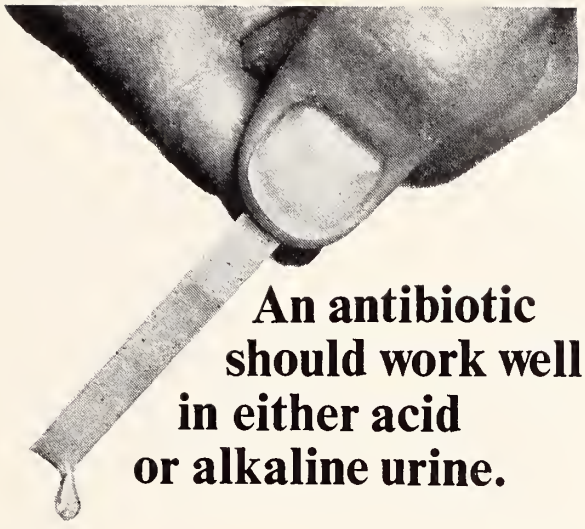
Entered as second class matter January 25, 1933, at the Postoffice at Indianapolis, Indiana. Copyright, 1968 by the Indiana State Medical Association. Published monthly at 3935 N. Meridian, Indianapolis 46208.

Second-class postage paid at Indianapolis, Indiana and at additional mailing office.

All issues of 1967 and subsequently may be obtained on microfilm. Address The Journal for details.

About Our Cover

on page 1418.



An antibiotic should work well in either acid or alkaline urine.

It isn't always necessary to adjust urinary pH in treating G.U. infections.

Not when the causative organism is a strain sensitive to DECLOMYCIN® Demethylchlortetracycline, as is often the case.

DECLOMYCIN remains stable and active in either acid or alkaline urine. So there's no need to acidify the urine to keep the antibiotic at work.

Why match the urine to the antibiotic...when you can match the antibiotic to the urine...by prescribing DECLOMYCIN. A b.i.d. dosage makes therapy convenient for your patient.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system – anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin – maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney – rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions–urticaria, angioneurotic edema, anaphylaxis. Teeth – dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; Tablets: film coated – 300 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

356-B

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545

ANNUAL CONVENTION—OCTOBER 15-18, 1968—FORT WAYNE

OFFICERS FOR 1967-68

President—G. O. Larson, M.D., 1110 Indiana Ave., LaPorte 46350.

President-Elect—Patrick J. V. Corcoran, 3700 Bellemeade, Evansville 47715.

Treasurer—Lester H. Hoyt, M.D., Methodist Hospital, Indianapolis 46202.

Assistant Treasurer—Malcolm O. Scamahorn, Pittsboro 46167.

Executive Secretary—Mr. James A. Waggener, 3935 N. Meridian, Indianapolis 46208.

COUNCILORS

District	Term Expires
1—Gilbert M. Wilhelmus, Evansville	Oct. 1968
2—Joe Dukes, Dugger	Oct. 1969
3—Donald M. Kerr, Bedford	Oct. 1970
4—Robert M. Reid, Columbus	Oct. 1968
5—Wilbert McIntosh, Riley	Oct. 1969
6—Stephen D. Smith, Knightstown	Oct. 1970
7—Albert M. Donato, Indianapolis	Oct. 1968
8—Donald R. Taylor, Muncie	Oct. 1969
9—Peter R. Petrich, Attica	Oct. 1970
10—Lowell H. Steen, Whiting (Chairman)	Oct. 1968
11—Lowell Hillis, Logansport	Oct. 1969
12—William R. Clark, Fort Wayne	Oct. 1970
13—Otis R. Bowen, Bremen	Oct. 1968

ALTERNATE COUNCILORS

District	Term Expires
1—Eugene Austin, Evansville	1970
2—Betty Dukes, Dugger	1968
3—Elmer L. Wallace, New Albany	1968
4—Jack E. Shields, Brownstown	1970
5—Cleon M. Schauwecker, Greencastle	1970
6—Frank Green, Rushville	1969
7—John O. Butler, Indianapolis	1969
8—Paul Sparks, Winchester	1970
9—Clarence G. Kern, Lebanon	1968
10—Herman Wing, Gary	1969
11—James A. Harshman, Kokomo	1968
12—Frederic L. Schoen, Fort Wayne	1970
13—George B. Gattman, Elkhart	1970

SECTION OFFICERS 1967-68

Section on Surgery:
Chairman—Donald M. Schlegel, Indianapolis
Vice-chairman—Henry Larzelere, Marion
Secretary—Austin Gardner, Indianapolis

Section on Internal Medicine:
Chairman—I. E. Michael, Indianapolis
Vice-chairman—Louis Sandock, South Bend
Secretary—Robert L. Rudesill, Indianapolis

Section on Ophthalmology and Otolaryngology:
Chairman—David E. Brown, Indianapolis
Vice-chairman—Kenneth F. Isenogle, Fort Wayne
Secretary—George A. Clark, Indianapolis

Section on Anesthesiology:
Chairman—William M. Matthews, Indianapolis
Vice-chairman—Merle E. Pickett, Fort Wayne
Secretary—Jerry R. Miller, Indianapolis

Section on General Practice:
Chairman—Jay S. Reese, Martinsville
Vice-chairman—Robert Mouser, Indianapolis
Secretary—Richard Juergens, Fort Wayne

Section on Obstetrics and Gynecology:
Chairman—Robert M. Reid, Columbus
Vice-chairman—Tom W. Wachob, Jr., Kokomo
Secretary—Charles R. Echt, Indianapolis

Section on Public Health and Preventive Medicine:
Chairman—Donald M. Kerr, Bedford
Vice-chairman—T. Neal Petry, Delphi
Secretary—Henry G. Nester, Indianapolis

Section on Radiology:
Chairman—John A. Robb, Indianapolis
Vice-chairman—Robert E. Beck, Evansville
Secretary—Dale B. Parshall, Elkhart

Section on Nervous and Mental Diseases:
Chairman—Gordon T. Brown, Indianapolis
Vice-chairman—James E. Benson, Elkhart
Secretary—Wesley A. Kissel, Indianapolis

Section on Pathology:
Chairman—Robert J. Frost, Michigan City
Vice-chairman—Frank Vellios, Indianapolis
Secretary—Robert L. Costin, Indianapolis

Section on Pediatrics:
Chairman—Roland E. Miller, Lafayette
Vice-chairman—Gustaf W. Erickson, South Bend
Secretary—Morris Green, Indianapolis

DELEGATES TO THE AMA

Terms expire December 31, 1968:

Delegates	Alternates
Harold C. Ochsner, Indianapolis	Don E. Wood, Indianapolis
Eugene F. Senseny, Fort Wayne	Robert M. Brown, Marion
Frank H. Green, Rushville	Kenneth O. Neumann, Lafayette

Terms expire December 31, 1969:

Delegates	Alternates
Guy A. Owsley, Hartford City	Maurice E. Glock, Fort Wayne
Jack E. Shields, Brownstown	Dwight W. Schuster, Indianapolis

"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.

COUNTY MEDICAL SOCIETY DIRECTORY

COUNTY	PRESIDENT	SECRETARY
Adams	Arthur H. Girod, Decatur	Harold F. Zwick, 227 S. Second St., Decatur
Allen (Fort Wayne)	Frederic L. Schoen, Fort Wayne	Eugene E. Schmidt, Suite 725, Indiana Bank Bldg., Fort Wayne
		Mr. Larry L. Pickering, Exec. Secy., 212 Med. Ctr. Bldg., Fort Wayne
Bartholomew-Brown	Harold W. Richmond, Columbus	C. David Ryan, 2600 Sandcrest Blvd., Columbus
Benton	A. L. Coddens, Earl Park	D. L. McKinney, Box 398, Otterbein
Boone	James R. McAfee, Lebanon	Katherine A. Jackson, 95 E. Oak St., Zionsville
Carroll	Marilyn L. Wagoner, Burlington	Robert Seese, 101 W. North St., Delphi
Cass	Joseph S. Bean, Logansport	Edward L. TerBush, 216 Ninth Street, Logansport
Clark	Robert K. McKechnie, Jeffersonville	Hassi Shina, Charlestown
Clay	J. Frank Maurer, Brazil	Forrest R. Buell, 314 Lankford St., Clay City
Clinton	Bruce A. Work, Frankfort	George K. Hammersley, 361 E. Clinton St., Frankfort
Daviess-Martin	A. G. Blazey, Washington	Hamlin B. Lindsay, 511 E. Main St., Washington
Dearborn-Ohio	Fred D. Houston, Lawrenceburg	Leslie M. Baker, 501 Fourth St., Aurora
Decatur	Dale D. Dickson, Greensburg	Arnold D. Ducanes, 215 N. Franklin St., Greensburg
DeKalb	John C. Harvey, Auburn	C. Bishop Hathaway, 209 N. Jackson St., Auburn
Delaware-Blackford	Glynn A. Rivers, Muncie	Richard N. Philbert, 2810 Ethel Ave., Muncie
Dubois	John P. Salb, Jasper	Edward Ploetner, 111-115 Central Bldg., Jasper
Elkhart	Philip G. Bowser, Goshen	Page E. Spray, 320 W. High St., Elkhart
Fayette-Franklin	B. W. Sanders, Connersville	J. L. Steinem, 818 Grand Ave., Connersville
Floyd	William F. Ruoff, New Albany	Daniel H. Cannon, 1201 E. Spring St., New Albany
Fountain-Warren	Max N. Hoffman, Covington	Theodore Person, 601 N. Mill St., Veedersburg
Fulton	Joseph D. Richardson, Rochester	F. Richard Walton, 116 W. 9th St., Rochester
Gibson	William E. Dye, Oakland City	David H. Lindauer, 115 N. Prince St., Princeton
Grant	J. C. Jarrett, Marion	Robert G. Young, 1207 Northwood Ct., Marion
Greene	Robert Moses, Worthington	Harry Rotman, Jasonville
Hamilton	John S. Hash, Noblesville	H. R. Blackburn, Riverview Hospital, Noblesville
Hancock	John J. Farrell, Greenfield	Joseph A. Miller, Oaklandon
Harrison-Crawford	Carl Dillman, Corydon	Richard A. Jordan, Corydon
Hendricks	Eli Coats, Indianapolis	Carl J. Heinlein, 637 E. Main, Danville
Henry	John E. Fisher, New Castle	Phyllis Grant, 3007 S. 14th St., New Castle
Howard	Robert L. Michael, Kokomo	J. F. Doss, 3520 Lafountain, Kokomo
Huntington	Wayne S. Miller, Huntington	Stanton E. Cope, 1022 N. Jefferson St., Huntington
Jackson-Jennings	Kenneth E. Bobb, Seymour	William F. Blaisdell, 207 N. Pine, Seymour
Jasper	Ernest R. Beaver, Rensselaer	Francis E. O'Brien, McKinley and Washington Sts., Rensselaer
Jay	Ralph Steffy, Portland	Elizabeth Tate, 317 S. Main St., Dunkirk
Jefferson-Switzerland	Elton Heaton, Madison	Ott B. McAtee, Madison State Hospital, Madison
Johnson	George Brown, Greenwood	Charles Link, 365 E. Main St., Greenwood
Knox	Boyd K. Black, Vincennes	John S. Murray, 317 Security Bank Bldg., Vincennes
Kosciusko	Wymond B. Wilson, Mentone	Arthur L. Moser, 600 Winona, Warsaw
LaGrange	Michael O. Mellinger, LaGrange	Allen S. Martin, Box 3A, Shipshewana
Lake	Seymour W. Shapiro, Gary	Reginald R. Barton, 7737 Forrest Ave., Gary
		Mr. John B. Twyman, Ex. Dir., 4640 W. 5th Ave., Gary
LaPorte	William E. Wolf, LaPorte	James J. J. Sprecher, 1001 Maple Ave., LaPorte
		Mrs. Polly Dent, Exec. Dir., 903 Indiana Ave., LaPorte
Lawrence	George W. Sorrells, Bedford	Reid C. Crosby, 11 Saddler Ct., Bedford
Madison	John R. Wagoner, Anderson	William M. Stinson, 333 Jackson St., Anderson
Marion	Hugh K. Thatcher, Indianapolis	A. Alan Fischer, 3500 Lafayette Rd., Suite 203, Indianapolis
		Mr. Arthur G. Loftin, Exec. Secy., 211 N. Delaware St., Indianapolis
Marshall	John K. Guild, Plymouth	M. George Rosero, Kewanna
Miami	Parker W. Snyder, Peru	Gordon S. Crates, Denver
Montgomery	V. G. Viray, Crawfordsville	W. E. Shannon, 408 W. Market St., Crawfordsville
Morgan	George Ostheimer, Martinsville	Maurice A. Turner, 10½ N. Main St., Martinsville
Newton	John Parker, Goodland	Arthur Schoonveld, Brook
Noble	O. Thomas Slough, Kendallville	Joseph Greenlee, Avilla
Orange	Charles X. McCalla, Paoli	Phillip T. Hodgin, Orleans
Owen-Monroe	Brad Bomba, Bloomington	Philip R. Karsell, 3901 E. 3rd St., Bloomington
Parke-Vermillion	John Somerville, Clinton	Milton Herzberg, Clinton
Perry	Robert Gilbert, Tell City	Gene E. Ress, 507 Main St., Tell City
Pike	M. H. Omstead, Petersburg	M. H. Omstead, Petersburg
Porter	John E. Read, Chesterton	Milton R. Carlson, 14000 Central, Portage
Posey	Paul Boren, Poseyville	Herman Hirsch, 130 W. 5th St., Mt. Vernon
Pulaski	Henry R. Eshelman, Monterey	E. L. Hollenberg, 613 Tippecanoe Dr., Winamac
Putnam	James B. Johnson, Greencastle	Anne S. Nichols, 707 E. Seminary, Greencastle
Randolph	Howard W. Koch, Winchester	Paul W. Sparks, 214 S. Main St., Winchester
Ripley	Bill E. Freeland, Batesville	William J. Warn, Milan
Rush	Donald I. Dean, Rushville	Charles E. Sheets, Manilla
St. Joseph	Jacob Rosenwasser, Mishawaka	L. F. Sandock, 503 Sherland Bldg., South Bend
		Mr. Harry Davis, Exec. Secy., 106 W. Monroe, South Bend
Scott	Ignacio B. Castro, Shelbyville	Jesus C. Bacala, 69 Wardell St., Scottsburg
Shelby	P. M. Inlow, Shelbyville	R. P. Inlow, 103 W. Washington St., Shelbyville
Spencer	John C. Glackman, Jr., Rockport	Michael O. Monar, Rockport
Starke	Earl Leinbach, Hamlet	W. Allen Palmer, Knox
Steuben	Mary H. Cameron, Angola	Richard W. Artz, 416 E. Maumee St., Angola
Sullivan	M. H. Bedwell, Sullivan	J. S. Brown, Carlisle
Tippecanoe	L. H. Wagner, Lafayette	Chester L. Waits, 49 N. 26th St., Lafayette
Tipton	Robert L. Haller, Kempton	Albert E. Stouder, Kempton
Vanderburgh	Ralph Carlson, Evansville	Mr. Arthur P. Tiernan, Exec. Secy., 109½ S. E. 3rd., Evansville
Vigo	John Freed, Terre Haute	Robert L. Meissel, 920 N. 19th St., Terre Haute
Wabash	Fred C. Poehler, LaFontaine	Frank Smyrniotis, 645 Spring St., Wabash
Warrick	Peter B. Hoover, Boonville	Robert C. Colvin, Newburgh
Washington	Eddie R. Apple, Salem	Truman L. Chastain, 906 W. Mulberry, Salem
Wayne-Union	John Stepleton, Richmond	John Dehner, Reid Memorial Hospital, Richmond
Wells	Charles Caylor, Bluffton	R. D. Willard, R. R. 4, Bluffton
White	W. M. Dickerson, Monticello	M. Ali Jehanyar, 116 N. Illinois, Monticello
Whitley	Verlin P. Huffman, S. Whitley	Thomas Hamilton, 115 S. Main St., Columbia City

Sources of Sinus Headache

Sinus headache is often a reflection of congestion in the nasal mucosa. The pain that results in the various regions of the head may help in determining the particular structure(s) responsible. The proved formula of Sinutab which provides triple action — analgesic, decongestant and antihistaminic — is specifically designed for the symptomatic relief of sinus headache and nasal congestion.

INDICATIONS: Sinutab is indicated for the symptomatic relief of headache, facial pain, malaise, fever, nasal and sinus congestion often associated with acute and chronic sinusitis, allergic rhinitis, vasomotor rhinitis, influenza, and the common cold.

ADVERSE REACTIONS: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

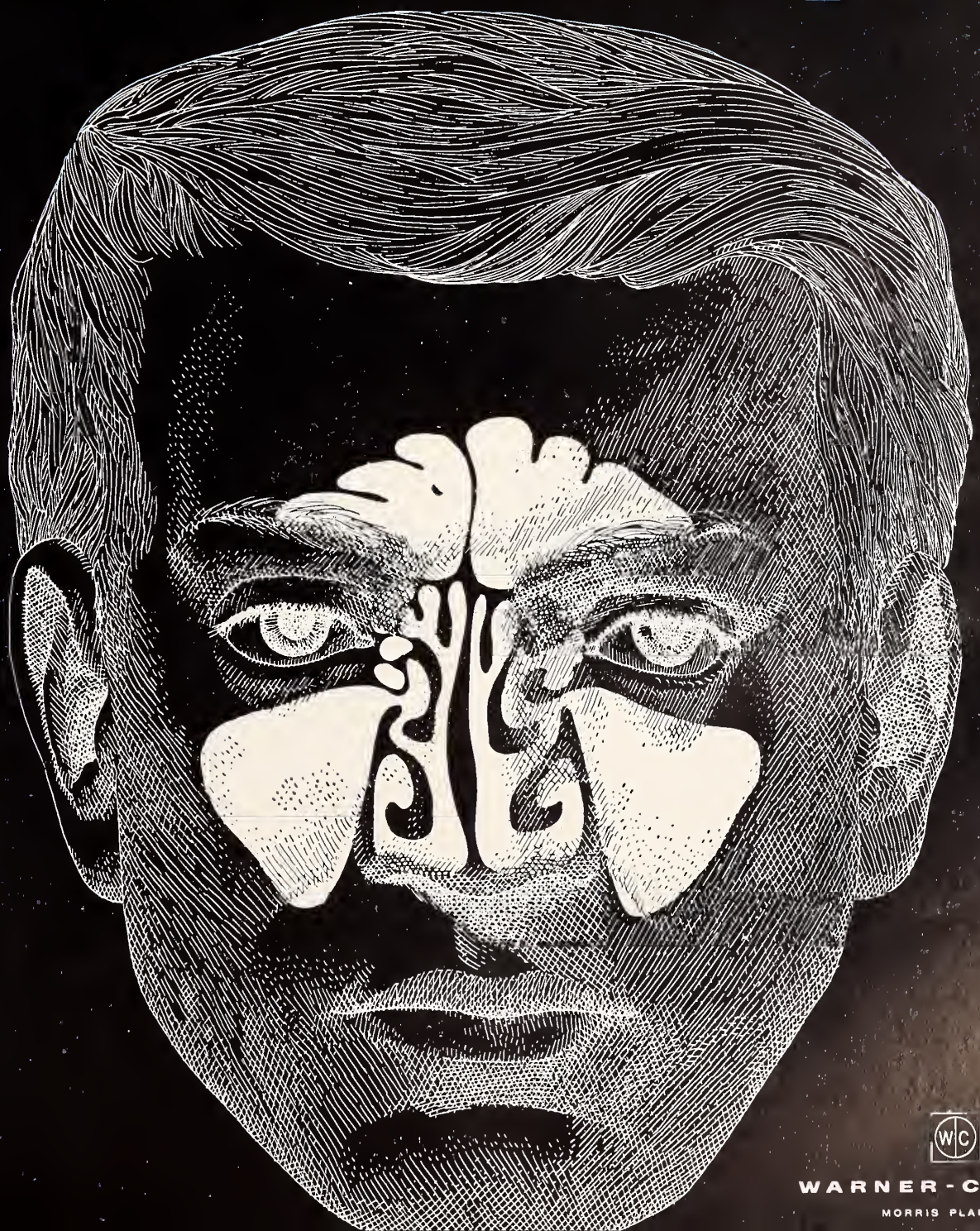
PRECAUTIONS: Instruct patients not to drive or operate machinery if drowsiness occurs. Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

DOSAGE: Adults — 2 tablets every 4 hours.
Children (6-12 years) — ½ the adult dose.

Each tablet contains 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

Source of Symptomatic Relief

Sinutab® | 2 tabs. q.4h.



WC

WARNER-CHILCOTT

MORRIS PLAINS, N.J.

ISMA Committees and Commissions for 1967–1968

COMMITTEES

Executive
Ralph V. Everly, Indianapolis, chairman; Burton E. Kintner, Elkhart; G. O. Larson, LaPorte, President; Patrick J. V. Corcoran, Evansville, President-Elect; Lowell H. Steen, Whiting, Chairman of the Council; Lester H. Hoyt, Indianapolis, Treasurer; Malcolm O. Scamahorn, Pittsboro, Assistant Treasurer.

Grievance
Philip B. Reed, Indianapolis, chairman; Eugene S. Rifner, Van Buren, vice-chairman; Robert G. Young, Marion, secretary; Kenneth L. Olson, South Bend, Earl W. Mericle, Indianapolis; Richard Bloomer, Rockville; John M. Paris, New Albany; Wilson L. Dalton, Shelbyville; William R. Noe, Bedford.

Student Loan
G. O. Larson, LaPorte; Lester H. Hoyt, Indianapolis; Glenn W. Irwin, Indianapolis; Donald R. Taylor, Muncie; James O. Ritchey, Indianapolis; Lester D. Bibler, Indianapolis; Mr. Robert Robinson, Indianapolis.

Medical-Legal Review
Lall G. Montgomery, Muncie; Truman E. Caylor, Bluffton; E. Rogers Smith, Indianapolis

COMMISSIONS

Aging
George M. Young, Gary, Chairman; A. W. Cavins, Terre Haute, Vice-Chairman; Raymond Duncan, Bedford, Secretary; Bernard B. Rosenblatt, Evansville; R. E. Buckingham, Bloomington; Walter S. Fisher, Columbus; Glen A. Ramsdell, Richmond; John O. Butler, Indianapolis; John Cullison, Muncie; Wallace R. Van Den Bosch, Lafayette; George W. Wagoner, Delphi; Nathan Salon, Fort Wayne; Donald T. Olson, South Bend; Andrew C. Offutt, Indianapolis; Wendell C. Anderson, Indianapolis.

Constitution and Bylaws
Gordon S. Fessler, Rising Sun, Chairman; William M. Sholty, Lafayette, Vice-Chairman; James F. Lewis, Liberty, Secretary; George W. Willison, Evansville; Thomas H. Gootee, Jasper; M. C. Topping, Terre Haute; Joseph F. Ferrara, Franklin; B. D. Wagoner, Union City; Chester L. Waits, Lafayette; O. L. Marks, East Chicago; Richard L. Glendening, Logansport; John S. Farquhar, Fort Wayne; Edwin C. Mueller, La Porte; Burton Kintner, Elkhart.

Convention Arrangements
Charles H. Aust, Fort Wayne, Chairman; Durward W. Paris, Kokomo, Vice-Chairman; William M. Kendrick, Mooresville, Secretary; Richard B. Hovda, Evansville; William F. Howard, Bloomington; Irvin Sonne, New Albany; Merritt O. Alcorn, Madison; John E. Freed, Jr., Terre Haute; John Mader, Richmond; Francis E. Stout, Muncie; Boyd A. Burkhardt, Tipton; John L. Ferry, Whiting; James D. Finfrock, Elkhart; Kenneth Kohlstaedt, Indianapolis; Charles Fisch, Indianapolis.

Governmental Medical Services
Charles Hendrix, Vincennes; Guy H. Waldo, Bedford; Herman Echsner, Columbus; Dick J. Steele, Greencastle; Tom S. Shields, Richmond; Robert P. Scott, Indianapolis; J. F. Hinchman, Parker; Ramon B. Dubois, Lafayette; Edward J. Dierolf, Gary; George D. Buckner, Fort Wayne; D. D. Swihart, Elkhart; Jerome E. Holman, Jr., Indianapolis; Glen V. Ryan, Indianapolis.

Inter-Professional Relations
Fred Flora, Frankfort, Chairman; Virgil E. Angel, Highland, Vice-Chairman; William S. Robertson, Spiceland, Secretary; A. Wayne Ratcliffe, Evansville; Philip R. Karsell, Bloomington; Charles X. McCalla, Paoli; John W. Ripley, Seymour; Richard L. Veach, Bainbridge; Willis W. Stogsdill, Indianapolis; Wendell Covalt, Muncie; H. H. Dunham, Wabash; Pierre C. Talbert, Bluffton; A. Alan Fischer, Indianapolis; Robert G. Husted, Munster.

Legislation
Dwight W. Schuster, Indianapolis, Chairman; Don E. Wood, Indianapolis, Vice-Chairman; Jack W. Hickman, Indianapolis, Secretary; Daniel M. Hare, Evansville; Harold Manifold, Bloomington; Elmer L. Wallace, New Albany; Leslie M. Baker, Aurora; Fred W. Dierdorf, Terre Haute; John Davis, Flat Rock; Guy A. Owsley, Hartford City; Max N. Hoffman, Covington; Daniel Ramker, Hammond; Lester Renbarger, Marion; Eugene F. Senseny, Fort Wayne; Otis R. Bowen, Bremen.

Medical Economics and Insurance
Thomas G. Hamilton, Columbia City, Chairman; Thomas J. Conway, Terre Haute, Vice-Chairman; Chester A. Stayton, Jr., Indianapolis, Secretary; Charles M. Sinn, Evansville; Paul W. Holtzman, Bloomington; Edward J. Ploetner, Jasper; William A. Johnson, North Vernon; David R. Cain, New Castle; James M. Leffel, Indianapolis; Charles E. Geckler, Muncie; Kenneth O. Neumann, Lafayette; A. S. Kobak, Valparaiso; Richard Wagner, Huntington; Jack W. Hannah, Elkhart; William J. Miller, Lafayette.

Medical Education and Licensure
James B. Johnson, Greencastle, Chairman; John L. Cullison, Muncie, Vice-Chairman; Forrest LaFollette, Hammond, Secretary; John Sterne, Evansville; Betty Dukes, Dugger; John M. Paris, New Albany; Richard A. Snapp, Columbus; Frank Coble, Richmond, George T. Lukemeyer, Indianapolis; William Ringer, Williamsport; Leo Radigan, Gary; Lowell J. Hillis, Logansport; Joel Salon, Fort Wayne; Jene R. Bennett, South Bend; Merritt O. Alcorn, Madison; Peter J. Pilecki, Michigan City; Glenn W. Irwin, Jr., Indianapolis.

Public Health
T. O. Middleton, Bloomington, Chairman; Henry G. Nester, Indianapolis, Secretary; Daniel Hare, Evansville; Roy L. Fultz, Salem; R. M. Seibel, Nashville; Cleon M. Schauwecker, Greencastle; Wilson L. Dalton, Shelbyville; Stanley W. Burwell, Muncie; Theodore C. Person, Veedersburg; Gilbert Z. Given, East Chicago; Paul Sparks, Winchester; Theodore J. Smith, Whiting; Bertram Roth, Indianapolis; Charles H. Rushmore, Indianapolis, consultant.

Public Information
Frederic L. Schoen, Fort Wayne, Chairman; William B. Challman, Evansville, Vice-Chairman; William G. Moore, La Porte, Secretary; Louis Blessinger, Corydon; Herman J. Echsner, Columbus; William G. Bannon, Terre Haute; Robert D. Spindler, Shelbyville; Robert W. Harger, Indianapolis; Don W. Boyer, Lebanon; Thomas C. Chael, Munster; Fred C. Poehler, La Fontaine; Louis F. Sandock, South Bend; Loren H. Martin, Indianapolis.

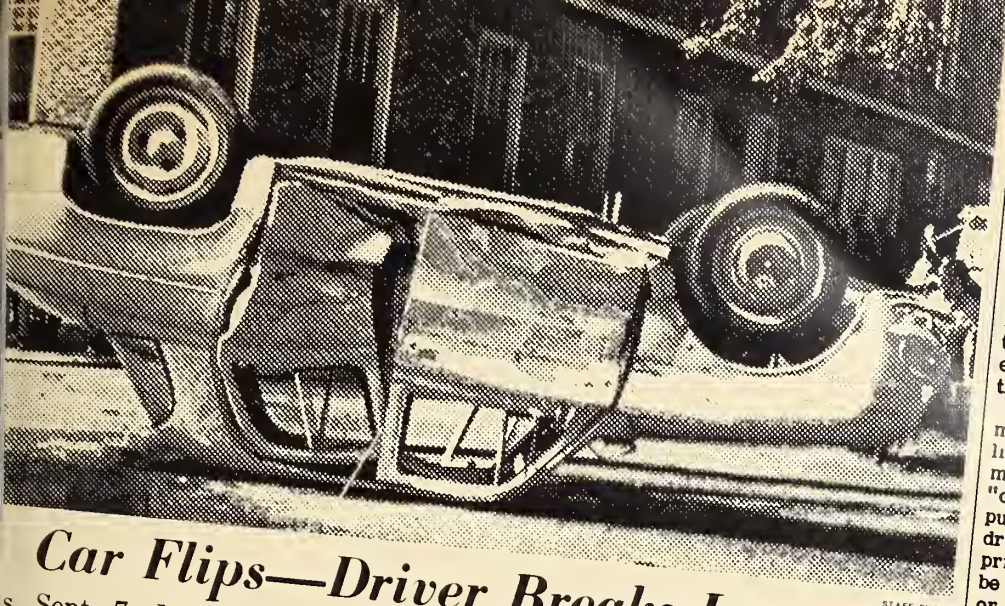
Special Activities
Marvin E. Priddy, Fort Wayne, Chairman; Robert M. Brown, Marion, Vice-Chairman; Norbert M. Welch, Vincennes; Robert O. Zink, Madison; John E. Freed, Jr., Terre Haute; Harold C. Ochsner, Indianapolis; Henry Bibler, Muncie; Clarence G. Kern, Lebanon; Adolph Walker, East Chicago; K. G. Hill, New Castle.

Voluntary Health Agencies
Norman R. Booher, Indianapolis, Chairman; James H. Gosman, Indianapolis, Vice-Chairman; M. O. Scamahorn, Pittsboro, Secretary; Albert Ritz, Evansville; Ed R. Cantwell, Vincennes; T. A. Neathamer, Scottsburg; Harry R. Baxter, Seymour; William G. Bannon, Terre Haute; Wayne Endicott, Greenfield; William A. Karsell, Indianapolis; James S. Fitzpatrick, Portland; Albert E. Applegate, Frankfort; John G. Kolettis, Gary; Lloyd L. Hill, Peru; Richard Willard, Bluffton; Frank McGue, Michigan City.

Future Planning Committee
Earl W. Mericle, Indianapolis, chairman; Maurice E. Glock Fort Wayne; James S. Fitzpatrick, Portland; A. Wayne Ratcliffe, Evansville; Fred S. Carter, LaPorte; William B. Challman, Mount Vernon; James E. Wenger, Nappanee; Charles F. Gillespie, Indianapolis; Leslie M. Baker, Aurora, (Ex-Officio Members)—Patrick J. V. Corcoran, Evansville; G. O. Larson, La Porte; Lowell H. Steen, Whiting; Ralph V. Everly, Indianapolis; Frank B. Ramsey, Indianapolis.

1967-68 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	R. E. Weitzel, Princeton	Fred Smith, Tell City	
2.	Brod Bombo, Bloomington	J. S. Brown, Corlisle	
3.	Doniel H. Connon, New Albony	Elmer L. Wallace, New Albony	April 2, 1969, New Albony
4.	Bill E. Freelond, Batesville	Williom J. Warn, Milon	
5.	Jock Somerville, Clinton	Milton Herzberg, Clinton	
6.	Stephen Smith, Knightstown	Dovid Wynegar, Richmond	
7.	John O. Butler, Indionopolis	Donald E. Stephens, Indianopolis	
8.	F. E. Stout, Muncie	Richard N. Philbert, Muncie	June 4, 1969, Muncie
9.	Mortin Dickerson, Monticello	M. Ali Jehanyar, Monticello	Moy 22, 1969, Lafoyette
10.	R. J. Doherty, Crown Point	Lambro Dimitroff, Calumet City, Ill.	
11.	John D. Pattison, Morion	Fred Poehler, La Fontoine	Sept., 17, 1969, Marion
12.	Kenneth F. Isenogle, Fort Woyne	John J. Hortmon, Angola	Moy 21, 1969, Fort Woyne
13.	John Kerrigan, Michigan City	John Hildebrond, South Bend	



STAFF PHOTO

Car Flips—Driver Breaks Leg

s, Sept. 7. John P. Jones of
incurred a broken leg today
driving
Patrolman B. R. Brown, the car hit a
fire hydrant and flipped over on its
Hasn't he
it

For se
board h
statemer
issue, a
tember th
fications'
ton dicta
Althou
made Mo
down by a
ter shar
flat obje
was pass
Board
McCredi
tion" s
elimir
the st
The c
ment ca
limit ra
mile li
"cut-of
public
dren
priv
be b
or th
schoo
The
so so
rather
burs

He's had enough excitement for one day.

For the patient who has been through an accident, the worry and anxiety following the experience may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—*to take the nervous "edge" off,* so the rest of the formula can control the pain more effectively.

Phenaphen® with Codeine

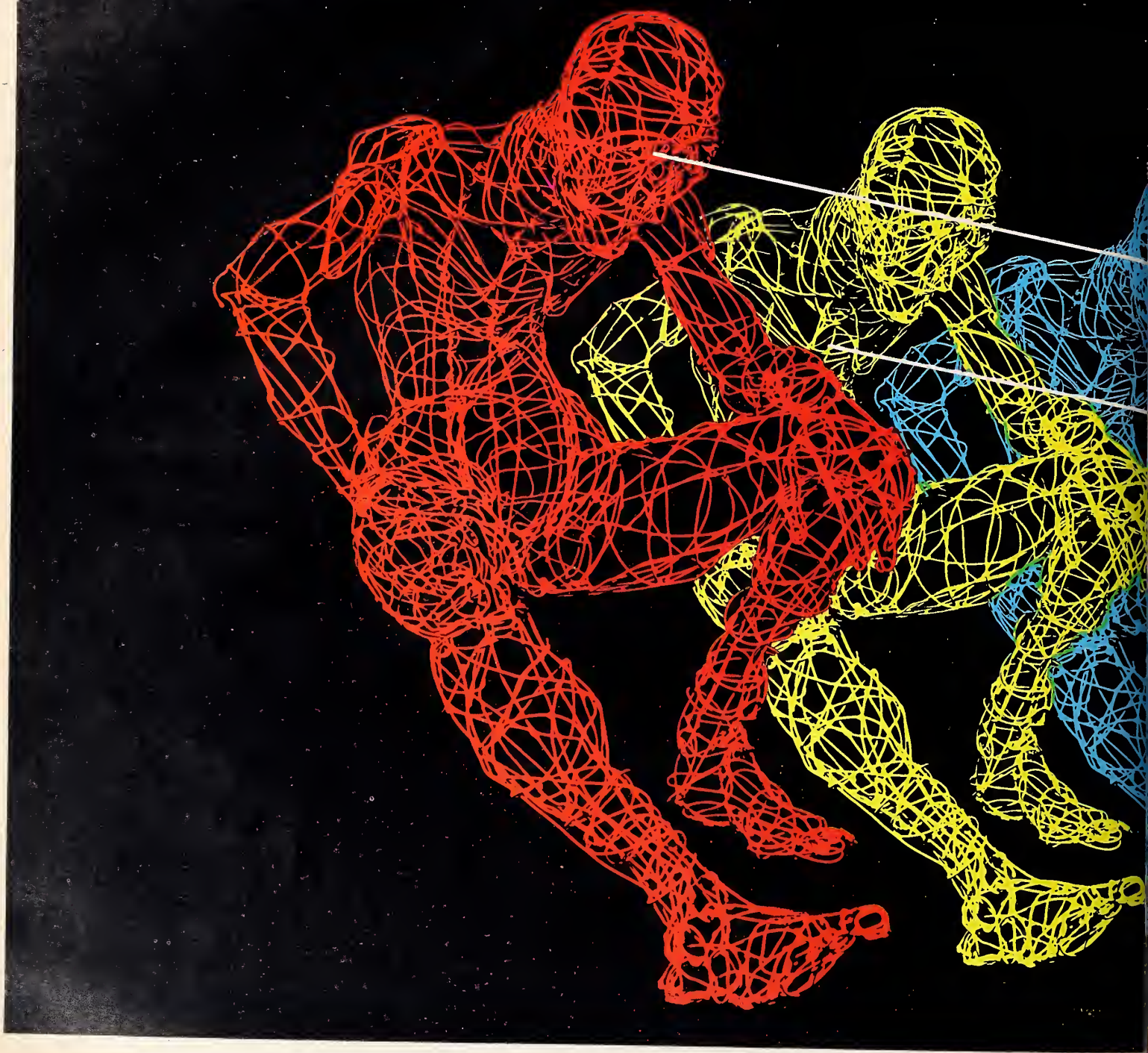
Phenaphen® with Codeine No. 2, No. 3, or No. 4 contains: *Phenobarbital* (¼ gr.), 16.2 mg. (Warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4). (Warning: may be habit forming).

THE COMPOUND ANALGESIC THAT CALMS INSTEAD OF CAFFEINATES

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** 1 or 2 capsules at 2 to 4 hour intervals, or as directed by physician. For further details see product literature.

A. H. ROBINS COMPANY
RICHMOND, VA. 23220 A·H·ROBINS

a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150	mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5	mcg.
Iron, Elemental (as Ferrous Fumarate)	110	mg.
Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

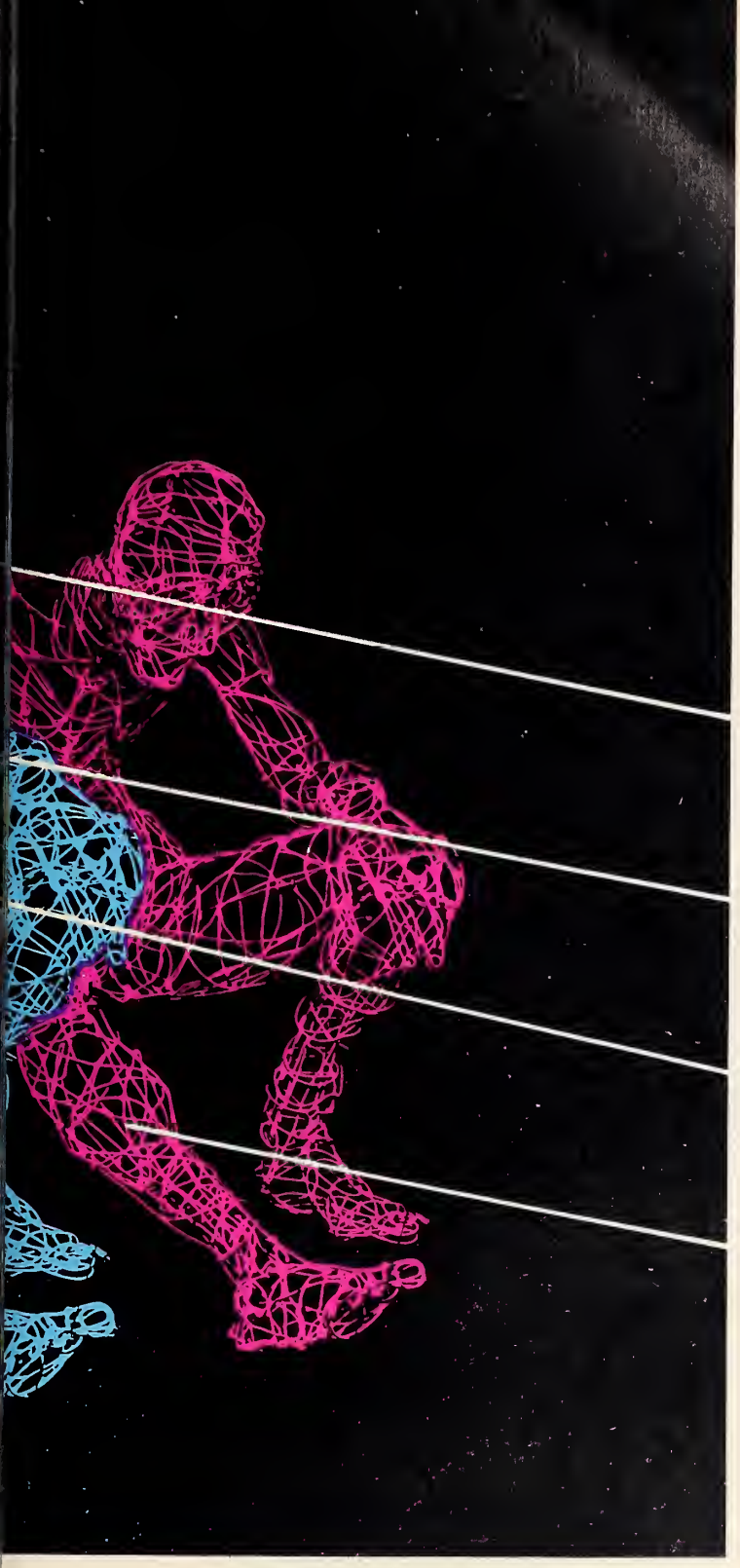
Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropriat investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequat vitamin B_{12} therapy may result in hematologic remission but neu rological progression. Adequate doses of vitamin B_{12} (parentera or oral with potent intrinsic factor as in Trinsicon® [hematini concentrate with intrinsic factor, Lilly]) usually prevent, halt, o improve the neurological changes.

As with all preparations containing intrinsic factor, resistanc may develop in some cases of pernicious anemia to the potentia tion of absorption of physiological doses of vitamin B_{12}. If resist ance occurs, parenteral therapy, or oral therapy with so-calle massive doses of vitamin B_{12}, may be necessary. No single regi men fits all cases, and the status of the patient observed i follow-up is the final criterion for adequacy of therapy. Periodi



You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500. [032568]

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206.

801668

Lilly

In peptic ulcer: the antacid puzzle

solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

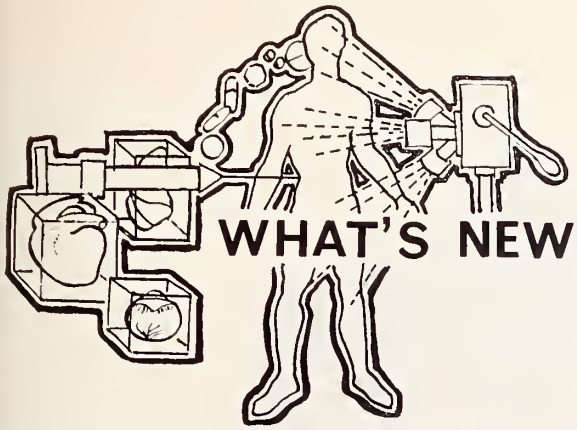
Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O. K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart
Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.



WHAT'S NEW?

Parke, Davis has introduced a system of tablet and capsule identification which will be applied to more than 200 different drugs. The system is known as PARCODE (**P**arke-Davis **A**ccurate **R**ecognition CODE.), and consists of the initials "P-D" and a three digit number which will be embossed or stamped on all coated or compressed tablets as well as on capsules and Kapseals. A pocket-sized handbook which lists the code will be distributed to all drug stores, doctors, hospitals and nursing homes in the U.S.

* * *

Weiler Products has a new "Dual-Purpose" San-Pan® which acts as an insert in a standard commode for the collection of excretory specimens or when filled with warm water to serve as a sitz bath utility. It is made of unbreakable plastic and may be autoclaved. It fits between the porcelain rim and the seat of the commode and is most convenient for collection of specimens from female patients or for the measurement of total urinary output. It also relieves the anxiety of children since the toilet process is familiar. Its use as a sitz bath is ideal in the home and also in the hospital where more elaborate equipment is not available.

* * *

A new type of oxygen hood developed for newborn infants has been announced by The Sierracin Corporation. It is formed of clear plastic and is shaped to surround the infant's head. It permits easy observation and is readily cleaned. The gases are diffused on entry into the mask in order to avoid drafts.

* * *

Scripto has a new sterile-pack pen which produces a fine line on the skin and may be used during sterile operative procedures. There is also a non-sterile model for ordinary skin-marking purposes. The semi-permanent non-toxic ink is non-tattooing and will withstand the usual surgical skin prep.

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of a product or recommendation for its use by THE JOURNAL or lished as news and does not necessarily constitute an indorsement of pharmaceuticals, clinical laboratory supplies, instruments, and surgical appliances and book publishers. Each item is pub-by the Indiana State Medical Association.

THE BETTMANN ARCHIVE

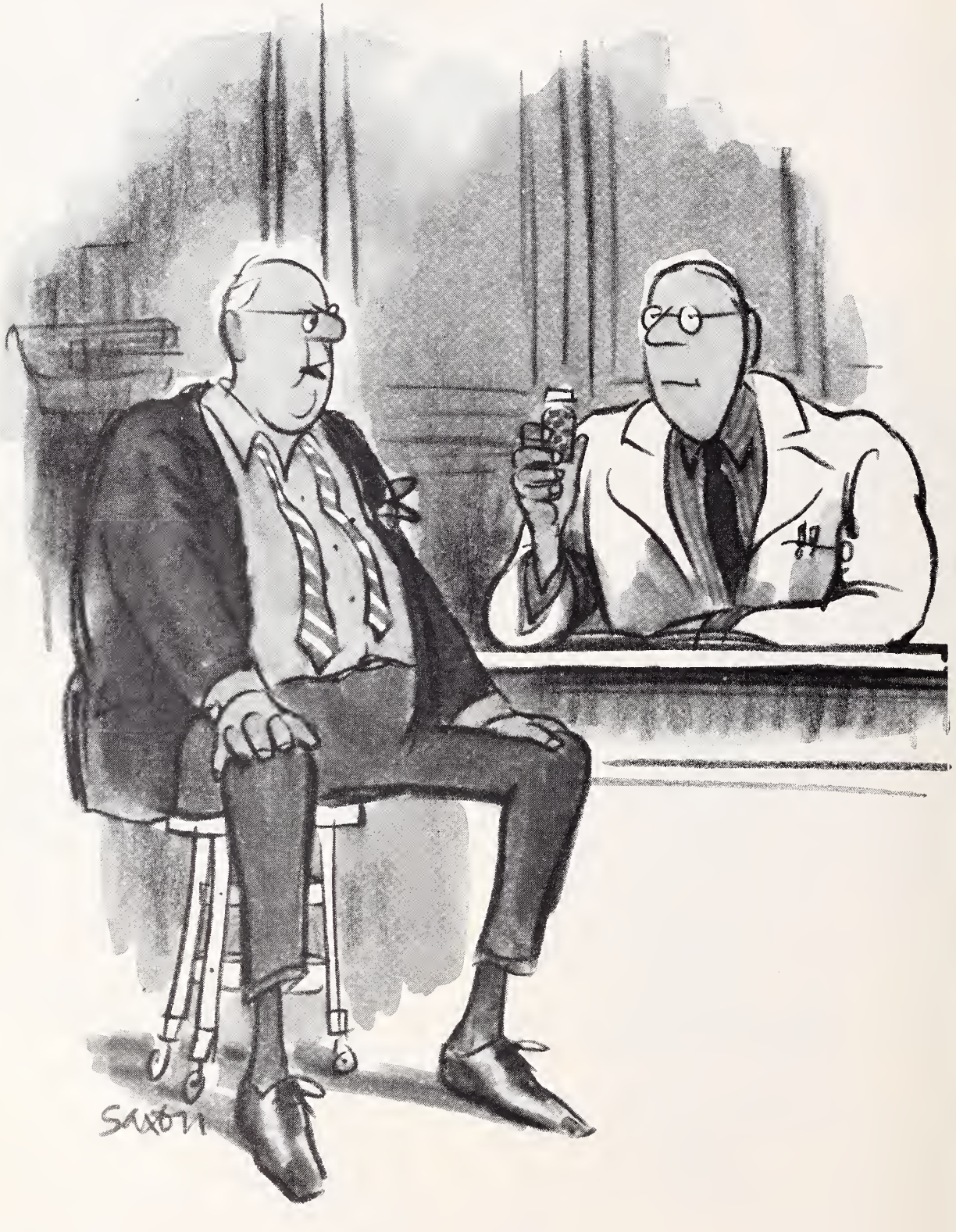
Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144



"Upper respiratory infection! I thought everything was a 'virus' these days?"

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® tablets in two different formulations.

And let you control the dosage.

With Novahistine LP tablets and Novahistine Singlet tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

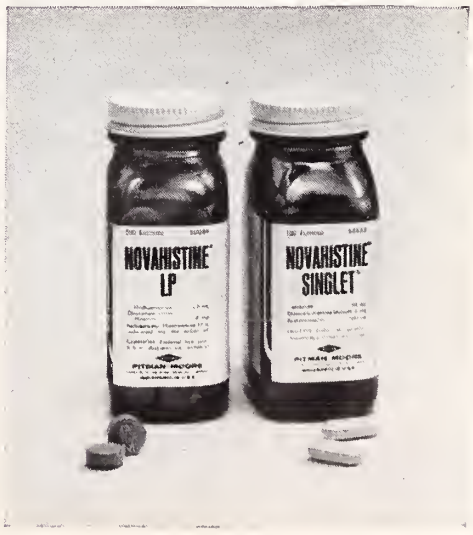
Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

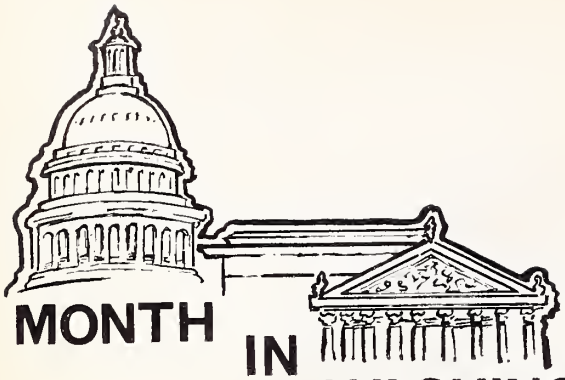
Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.

Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.



DOW PITMAN-MOORE DIVISION OF THE DOW CHEMICAL COMPANY, INDIANAPOLIS



MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

WASHINGTON, D.C.—President Johnson signed into law the Health Manpower Act of 1968 which extends for two years, until June 30, 1971, and expands the federal programs of aid to medical and allied health schools.

OTHER HEALTH legislation enacted into law: 1) establishes a National Eye Institute as part of the National Institutes of Health; 2) requires federal buildings to provide easy access to the handicapped; 3) authorizes standards to prevent gas lines from leaking and exploding.

PRESIDENT JOHNSON termed the health manpower law "a major measure in the battle for better health." It authorizes about $1.2 billion in federal aid to medical and other health personnel schools over two years for construction, expansion and operating expenses. Congress followed most of the Administration's proposals in approving the legislation but limited the extension to two years, instead of the four years requested.

SCHOOLS of pharmacy and veterinary medicine were made eligible for the first time.

MONEY authorizations for schools in the new law:
Medical and other health professions—construction grants, $395 million; institutional support, $285 million; scholarships, $32.8 million; student loans, $70 million; total, $782.8 million.

NURSING—construction, $60 million; institutional support, $75 million; traineeships, $34 million; scholarships, $50 million; student loans, $41 million; total, $260 million.

ALLIED HEALTH (fiscal 1970 only)—construction, $10 million; institutional support, $20 million; traineeships, $5 million; new methods, $4.5 million; total, $39.5 million.

PUBLIC HEALTH—graduate training, $20.5 million; traineeships, $24 million; total, $44.5 million.

HEALTH research construction, $50 million.

IMPORTANCE OF PRIVATE ENTERPRISE

BOTH THE Democratic and Republican 1968 national campaign platforms cited the importance of the role of private enterprise in the development of government health

programs. The GOP placed greater emphasis on private medicine than the Democratic party did.

"WHILE believing no American should be denied adequate medical treatment, we will be diligent in protecting the traditional patient-doctor relationship and the integrity of the medical practitioner," the Republican plank said.

THE REPUBLICAN platform also pledged "to encourage the broadening of private health insurance plans," including extension to cover mental illness.

"THROUGH a partnership of government and private enterprise, we must develop new coordinated approaches to stem the rise in medical costs without lowering the quality or availability of medical care," the Democratic platform said.

WITHOUT BEING specific, the Democrats indicated support for universal government health insurance or, at the least, wide expansion of Medicare or Medicaid (or both). Boasting of "giant steps" in the past eight years "in assuring life and health for its citizens," their platform said: "We Democrats are determined to take those final steps that are necessary to make certain that every American, regardless of economic status, shall live out his years without fear of the high costs of sickness."

THE DEMOCRATIC health plank also said medical costs could be lowered by more out-of-hospital care, comprehensive group practice arrangements, increased availability of neighborhood health centers and the greater use of sub-professional aides.

THE REPUBLICAN platform said "inflation produced by the Johnson-Humphrey Administration" was a major factor in the increases in health care costs.

AMERICAN MEDICAL ASSOCIATION spokesmen appeared before the platform committees of both parties at pre-convention hearings. Dr. Donald E. Wood, Indianapolis, Ind., chairman of the AMA's Council on Legislative Activities, testified at the Republican hearing; Dr. John R. Kernodle, Burlington, N.C., a member of the AMA Board of Trustees, at the Democratic. Their statements were the same.

THE AMA statement expressed hope that the next federal administration, whether it be Democratic or Republican, "will provide men and women in medicine, and those engaged in the allied sciences, the opportunity to think and work in a free atmosphere to pursue their common goal of a better and more healthful life for everyone."

THE AMA emphasized the desirability of health programs being partnerships among private enterprise and federal, state and local governments. The AMA pledged its support to such cooperative programs for mental illness, infant mortality, occupational health and safety and education of physicians and allied health personnel.

CONCERNING health care costs, the AMA said:

"WE BELIEVE that programs to increase the production of medical

Continued

Continued

and other health personnel can be cooperatively and effectively undertaken. We are further firmly convinced that we can and must work toward health in the inflationary spiral, and toward a productive use of tax dollars expended in the health area. New and old tax-supported programs in the health field should be critically evaluated so that while the best health care is attained, overlapping, waste and unnecessary programming are avoided. In this regard, we recommend the establishment of a cabinet-level Department of Health, headed by a physician as secretary, with overall responsibility for all federal health programs, so that maximum effectiveness may be attained.

"WE HAVE always maintained that high-quality medical care should be available for all Americans, including those who need assistance in meeting the costs of such care . . . . Firmly convinced that adequate health insurance coverage is the choice mechanism for the financing of quality health care costs, we suggest that the country embark on a program of tax credits for health insurance premiums. Under such a plan, all individuals and families would be encouraged to provide themselves with health care cost protection, with those in financial need receiving the greater amount of tax credit on a graduated basis."

BRAND-NAME VS. GENERIC DRUGS

THE Food and Drug Administration and the Pharmaceutical Manufacturers Association differed as to the significance of the findings of a Georgetown University School of Medicine team after studies comparing three brand-name drugs with their generic versions.

DRUGS TESTED were diphenylhydantoin, prescribed for treatment of epilepsy, chloramphenicol and sulfisoxazole. The studies supported by the FDA showed:

1. Some generic drugs are absorbed more slowly by the body than the brand;
2. At least one generic drug was absorbed faster by the body than the brand drug;
3. Absorption rates were governed by such factors as crystal size of the drug, hardness of tablets and the types of drug capsules.

"OUR FINDINGS raise serious doubts about the equality of different products of the same drug in the treatment of disease," said Christopher M. Martin, M.D., Professor of Medicine and Pharmacology.

"THE STUDIES by Dr. Martin and his research team, showing how different versions of the same drug behave differently in man, provide further proof of the scientific fact that these differences can be significant in patients," C. Joseph Stetler, PMA President said.

"CLEARLY, there is no evidence to indicate that all formulations

Continued

Diagnostic Products Sales, The Dow Chemical Company, Midland, Michigan 48640.

Announcing the blood chemistries anyone in your office can do.

Those using Diagnostest* reagents and instruments. We train your nurse or medical assistant to use this simple, accurate system. For measuring hemoglobin, glucose, cholesterol, urea nitrogen, total bilirubin and uric acid. You get results in minutes. And the system includes everything you need. Write today for full information.

*Trademark of The Dow Chemical Company

DOW

of the same drug are equivalent. From all the evidence that has been developed to date, as Dr. Martin's studies point out, quite the opposite may be true."

ON THE other hand, FDA Commissioner Herbert Ley, Jr., M.D., said his agency "has in no sense concluded that 'generic' drugs are less effective as a class than 'brand-name' products."

"IN MY OPINION, there are fewer than two dozen drugs where therapeutic differences among competing products may be a problem," he said.

"DATA FROM the Georgetown work have been useful to the FDA, but it is completely unwarranted to reach any general conclusions about drug equivalency on the basis of these exploratory studies."

NEW MEDICARE CHIEF MEDICAL OFFICER

A RETIRED air force officer, Maj. Gen. Theodore C. Bedwell, Jr., M.D., 59, has been appointed to the newly-established post of chief medical officer for the medicare program. He will be liaison with the medical profession.

HE MOST RECENTLY was Director of Staff, Office of the Deputy Assistant Secretary of Defense (manpower—health and medical). A native of Texas, he was graduated from Baylor University Medical College. A holder of the distinguished service medal, Dr. Bedwell in 1962 received the American Medical Association's special aerospace medicine honor citation. ◀

Letters to the editor

To the Editor:

We greatly appreciate your past cooperation in publicizing our Doctor To Doctor Program in your journal and have received many offers of journals as a result of this notice.

As U.S.A. journals circulate around the world, our program becomes known to physicians overseas and, as a result, requests for journals increase in number. Since the requests come mostly from areas where exchange rates are almost prohibitive of individual subscription, we feel justified in asking your U.S.A. readers to pass along their journals after they have read them.

You will be interested, I am sure, in knowing that currently our Doctor To Doctor Program is active in 63 countries; 22 in Asia, 21 in Africa, 12 in Latin America, 8 elsewhere, and we are constantly receiving more requests.

Would you be kind enough to include a notice, editorial or a Letter to the Editor re-emphasizing our need for more offers of journals, particularly those in the specialties?

I regret any inconvenience caused you and trust we may count on your continued cooperation in bringing the needs of our program to your readers.

Sincerely yours,

Ada Chree Reid, M.D., Director

AMA DOCTOR TO DOCTOR PROGRAM

10 Columbus Circle—Room 1270

New York City 10019

To the Editor:

Rheumatism — gout — arthritis cure. What the doctors have been looking for for thousands of years, I found it.

I will show you how to cure those aches and pains, once and for all, without drugs, for the small sum of $90,000.

Yours truly,

(s) Elmer A. Kiewit

436 W. McMicken Ave.

Cincinnati, Ohio 45214

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.

The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.

A realistic approach to pain relief

Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.

New

Therapeutic breakthrough in non-narcotic control of the pain of

Tegretol®
carbamazepine

trigeminal neuralgia

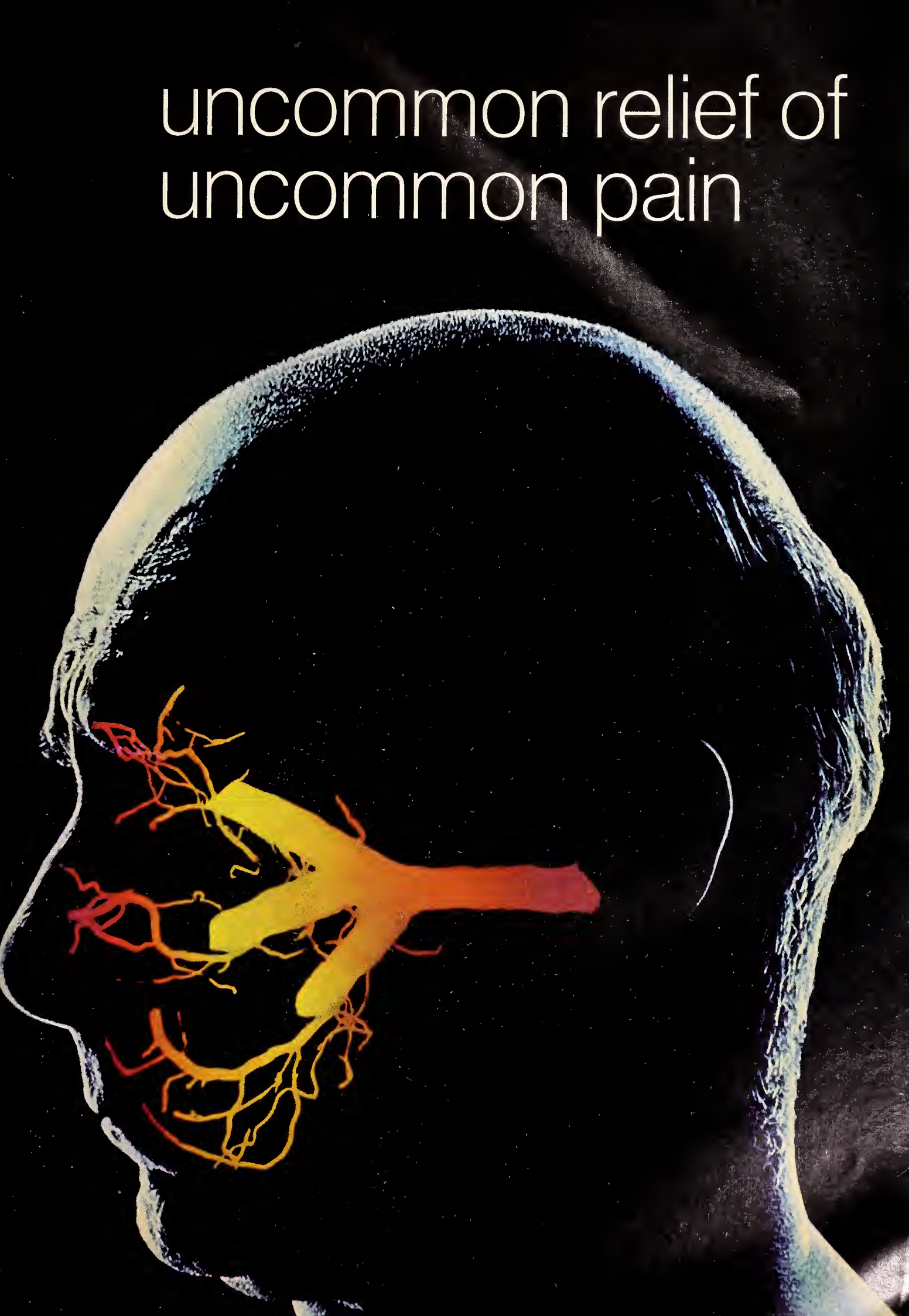
Warning
Fatal cases of aplastic anemia have been reported following treatment with Tegretol. Agranulocytosis, thrombocytopenia and transitory leukopenia have also been observed.
Complete blood and platelet counts should be done prior to and at regular intervals during treatment with the drug (see recommendations under "Important Note and Precautions") to help in the early detection of serious bone marrow injury. Abnormalities in initial blood tests should rule out use of the drug. Also, patients should be made aware of such early toxic signs of a potential hematologic problem as fever, sore throat, mouth ulcers, easy bruising and petechial or purpuric hemorrhage. Should such signs appear, the patient should be advised to discontinue the drug and to report to the physician immediately.

Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.
Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.
Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.
Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.
In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.
Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect.
Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.
Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.
Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.
Before initiating therapy, the following laboratory procedures should be performed:
1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.
2. Baseline evaluations of liver function.
During treatment with Tegretol, the following laboratory procedures should be performed:
1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent laboratory and clinical evaluations. Should this trend continue, the drug should be discontinued.
2. Liver function tests must be performed at regular intervals during treatment with this drug since liver damage may occur during therapy. The drug should be discontinued immediately in cases of aggravated liver dysfunction or active liver disease.
3. Periodic eye examinations, including slit-lamp, funduscopy and tonometry, are recommended for patients being treated with this drug since many phenothiazines and related drugs have been shown to cause eye changes.
4. Complete urinalysis and BUN should be done on patients treated with Tegretol because of observed renal dysfunction.
Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet, nausea, vomiting, aplastic anemia, transitory leukopenia, agranulocytosis, eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalities in liver function tests, cholestatic and hepatocellular jaundice, urinary frequency, acute urinary retention, oliguria with elevated blood pressure, albuminuria, glycosuria, elevated BUN, microscopic deposits in the urine, impotence, disturbances of coordination, confusion, headache, fatigue, blurred vision, transient diplopia and oculomotor disturbances, speech disturbances, abnormal involuntary movements, peripheral neuritis and paresthesias, depression with agitation, talkativeness, nystagmus, tinnitus, paralysis and other symptoms of cerebral arterial insufficiency, pruritic and erythematous rashes, urticaria, Stevens-Johnson syndrome, photosensitivity reactions, alterations in skin pigmentation, exfoliative dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, erythema multiforme and nodosum, aggravation of disseminated lupus erythematosus, gastric distress, abdominal pain, diarrhea, constipation, anorexia, dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills, adenopathy, lymphadenopathy, aching joints and muscles, leg cramps, conjunctivitis, left ventricular failure, aggravation of hypertension, hypotension, syncope and collapse, edema, aggravation of coronary artery disease and congestive heart failure. (Whether these cardiovascular effects are drug-related is not known. However, some of these complications have resulted in fatalities.) The necessity for discontinuing the drug should be dictated by the gravity and severity of the adverse reactions.
Dosage and Administration The drug should always be taken with meals, if possible.
Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, the dose should be increased in one-half tablet (100 mg.) increments every 12 hours until freedom from pain is achieved. To relieve pain, between 200 mg. and 1200 mg. per 24 hours may be necessary.
Maintenance: Initial control of pain can be maintained in most patients with a dose of 400 mg. to 800 mg. daily. Maintenance doses may range between 200 mg. and 1200 mg. daily.
At least once every 3 months during treatment period attempts should be made to discontinue the drug or to reduce the dose to the minimum effective level.
Availability Round, white, single-scored tablets of 200 mg. in bottles of 100 and 1000. (B)46-820-A
For complete details, please see Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Geigy

uncommon relief of uncommon pain



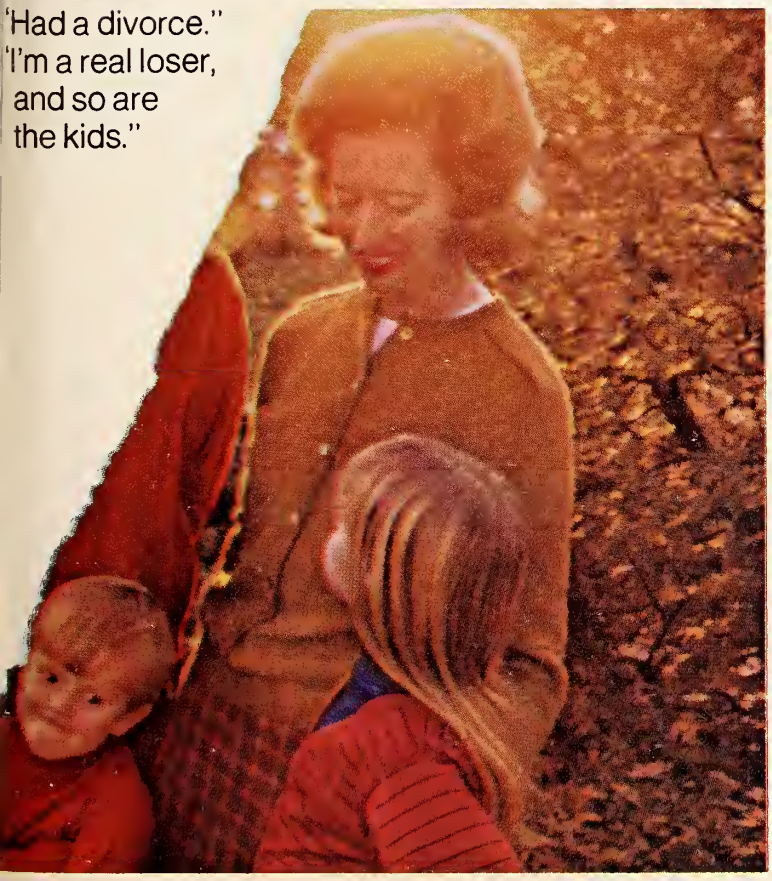
The Divorced Depressive: "Forty, Forgotten

"Had a large wedding."
"Had a fine home and family."

TO-5757

..Forlorn"

"Had a divorce."
"I'm a real loser,
and so are
the kids."



in depression

The loss of marital compatibility results in nearly 500,000 U.S. divorces each year.

Depression characterized by untold guilt feelings, grief and loneliness may follow.

When you diagnose depression, Tofrānil may be indicated for relief.

As maintenance therapy during the active phase of depression, Tofrānil can often help prevent relapse.

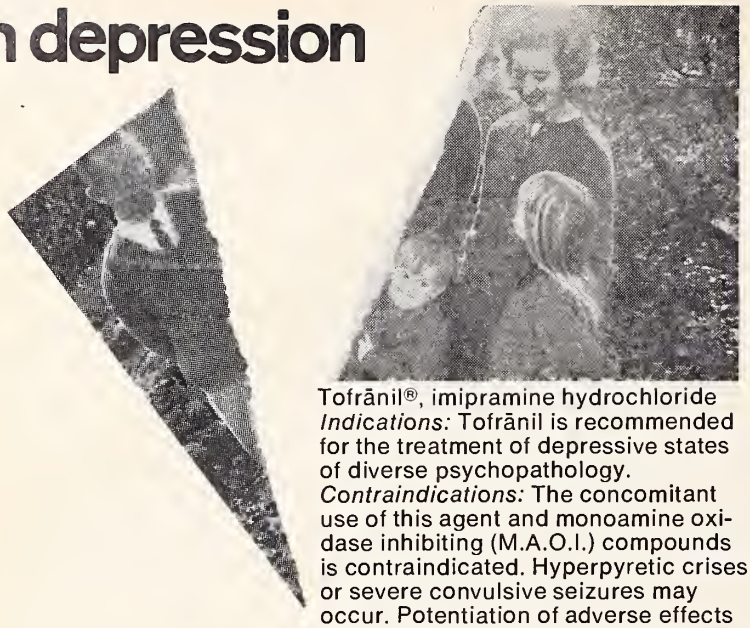
The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated. In patients with cardiovascular disease, thyroid disorders, increased intraocular pressure; in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication or antihypertensive adrenergic neuron-blocking agents; and in those in their first trimester of pregnancy–the special precautions listed in the Prescribing Information should be carefully observed.

Toxic reactions severe enough to require discontinuation of Tofrānil are uncommon. However, for complete details, please refer to the complete Prescribing Information.

Turn page for brief summary of Prescribing Information.

Tofrānil® imipramine hydrochloride
Geigy

in depression



Tofrānil® Geigy

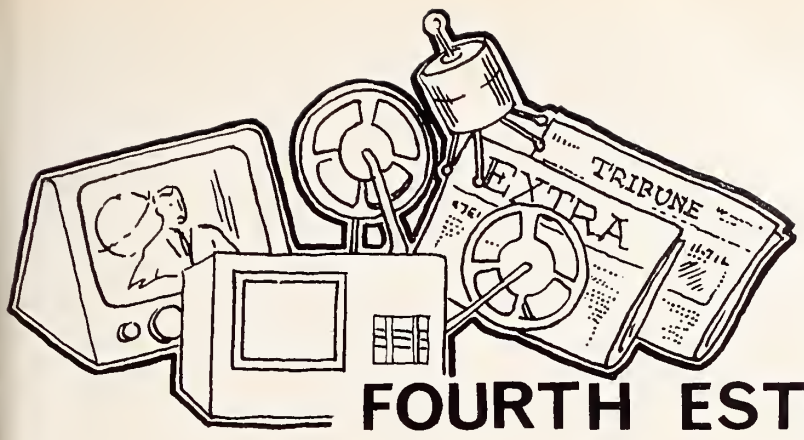
imipramine
hydrochloride

Tofrānil®, imipramine hydrochloride
Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy. Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy. Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when this compound was added to the regimen. Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 years of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (including hypomanic and manic episodes) which may require dosage reduction and/or addition of a tranquilizer or temporary discontinuation of the drug, epileptiform seizures, orthostatic hypotension and substantial blood pressure fall in hypertensive patients, purpura, transient jaundice, bone marrow depression including agranulocytosis, sensitization and skin rash including photosensitization, eosinophilia, and mild withdrawal symptoms on sudden discontinuation after prolonged treatment with high doses. Occasional hormonal effects (impotence, decreased libido, and estrogenic effects) may be observed. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those using anticholinergic agents (including antiparkinsonism drugs).
Outpatient Adult Dosage: Initially, 75 mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)R-46-850-C

For complete details, please refer to the full Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

TO-6757



FOURTH ESTATE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Area Medical Alert

Advocates of Lake County as a site for a branch of the Indiana University Medical School should take a close look at the newest developments down at Muncie.

Down there officials of Ball State University have announced plans for a two-year medical education program to be operated in conjunction with the I.U. Medical School at Indianapolis. I.U. officials quickly followed that up with a disclaimer of any direct connection with such a program. It would be surprising, nevertheless, if investigation showed there had been no tenuous liaison.

For one thing, the Ball State plan dovetails with one official I.U. position—that the university would prefer a group of such two-year centers feeding into the Indianapolis institution for final medical degree work. For another, Ball State is organically separated from I.U. and so would be more able to advance a plan of its own than would, for example, the Northwest I.U. Campus, largely centered in Gary.

But neither the two-year feeder program nor a near central state geographical location gets to the roots of the problem nearly so well as would a four-year medical school in Northwest Indiana.

The basic problem is a shortage of doctors throughout Indiana, except perhaps for Marion County (Indianapolis) where the medical school itself helps keep many doctors around. The shortage is particularly acute in Lake County — down more than 100 from the figure recommended by the U.S. Department of Health, Education and Welfare.

The Northwest Indiana population concentration, the improvement under way in the area's hospital facilities as a result primarily of the overwhelming success of the Greater Gary Joint Hospital drive, and the current shortage of physicians which would be considerably offset by construction of a medical school in our midst, all argue strongly for a Lake County location for a full four-year facility.

It will be necessary, however, to convince the Legislature and other state officials of the validity of this sector's contentions. It will be necessary, too, to remain alert to any possible moves elsewhere in the state which might obscure the logic of Lake County's position.—*Gary Post-Tribune*, July 7, 1968.

Branded Drugs Score

The Food and Drug Administration has been jolted by reports from its own testing programs which have cut some of the ground from under the FDA campaign to discredit brand-name drug products.

For a year the FDA has been running tests comparing about 50 brand-name products with drugs sold under the generic names of their active ingredients. The objective is to substantiate the claim that the generic drugs are just as good as the brand-name ones which usually cost more.

It was disclosed this week that reports so far have listed three brand-name products, two antibiotics and a sulfonamide, in which testing has established that the generic equivalents are not as effective as the brand-name products.

Differences in effectiveness have been traced to such things as the pressure used in making tablets, coatings on tablets and inactive ingredients which are added to control the performance of the drug. This is precisely what the Pharmaceutical Manufacturers Association has been saying—that things other than the active chemical are important to its effectiveness and that a brand name is an assurance of control in the quality of drugs in dose form.

Dr. Herbert L. Ley Jr., FDA commissioner, conceded that these findings are forcing the FDA to take another look, and to expand the testing program. We should hope so. When the FDA comes out with a declaration about the equivalency of generic and brand-name drugs, it had better be right.

On the basis of the assumption that there's no difference to justify the higher cost of brand-name drugs, President Johnson has proposed that the government establish a relatively narrow range of "reasonable" costs for drugs paid for under Medicare and other Federal programs. Presumably this would in most cases restrict prescriptions paid for with

Federal money to generic drugs.

It is an awesome responsibility which he is proposing that the government assume. It is the responsibility of ruling that medicines for patients under Federal programs be prescribed on the basis of their cost, instead of the doctor's judgment as to what the patient needs.

That responsibility ought to be left in the hands of the doctors.—*The Indianapolis Star*, July 22, 1968.

The Approach We Can't Knock

Several years ago the American Medical Association dipped deep into its capacious lobbying war chest and spent a bundle in a futile attempt to block Medicare.

Their campaign was spirited, but woefully inept. We broke many an editorial lance in behalf of their fight, but our efforts went astray, too.

Comes now the chiropractors who, seemingly, have learned a lesson. They have come up with a private program for the elderly called "Chirocare." The plan is being pushed by the International Chiropractors Association and has at least two participating chiropractor-members in Fort Wayne.

It should be noted that this move of the chiropractors is not 100% altruism. In announcing the program, Dr. L. W. Rutherford took a roundhouse swing at the AMA, charging that "influences from the medical lobby" have been instrumental in postponing passage of Medicare amendments which would extend the program to chiropractic care. He opined:

"Chiropractic care is available today to all people except the elderly. Insurance plans pay for chiropractors' services. Union health plans cover chiropractic care. And Workmen's Compensation makes provisions to pay chiropractors. But not Medicare."

It is not our purpose to pass judgment on the age-old controversy between the medical doctors and the chiropractors. We would observe that the controversy may have sparked one of its few tangible assets in the decision of the International Chiropractors Association's decision to launch Chirocare.

It combines self-help, plus a contribution in time and money on the part of participating chiropractors. Basically, a fee of $20 pays for a complete year of chiropractic care, with several minor exceptions.

We find the private enterprise approach of Chirocare hard to knock. —*Fort Wayne News-Sentinel*, July 27, 1968.

Does Indiana Need More Doctors?

The proposal for establishing one or more additional schools of medicine was a much-debated question during the 1967 session of the Indiana Legislature. The proposal also was one of the questions considered in the three-day workshop of the State Policy Commission on Post High School Education at French Lick last Friday, Saturday and Sunday.

The one school of medicine in Indiana—the Indiana University School of Medicine — is the largest medical school in the United States. Of the 181 young men graduated in 1966 about seventy stayed to serve their internships in Indiana. Of the 209 graduated in 1967, about 92 stayed in Indiana serving their internships. While a substantial proportion of the graduates accepted internships in Chicago and elsewhere, a number of rural Indiana counties remained short on doctors.

Efforts of legislators and lobbyists to have medical schools authorized at Muncie, Evansville, South Bend and Lake County in 1967 failed because of a number of reasons. Cost of a new medical school is estimated at between fifty and sixty million dollars at this time. In the meantime, an "Indiana plan" for providing more doctors has been suggested. It would provide for having pre-medic courses given in private colleges as well as in the four state universities, with the final two or three years given by the Indiana University School of Medicine, and internships available in hospitals in Muncie, South Bend, Evansville and Lake County. This would mean that the medical school which already is the largest in the nation would in the future graduate even a greater number than now.

In the meantime, more doctors are being retained in Indiana than previously as a result of the Indiana internship law enacted by the 1967 Legislature.

Decision as to whether a new medical school should be established, and where, should be based on something other than regional geographic or political considerations.

Indiana now, with 2½% of the population of the United States, graduates four percent of the physicians in the nation. But, still, there seems to be a shortage of doctors in Indiana. Solution of the problem involves a number of factors, with some complexity. Before any action, or decision, is announced, there should be further study. This, it is expected, will be made between now and December by the State Policy Commission on Post High School Education. It is an important subject and deserves the consideration of all doctors as well as all other citizens.—*Corydon Democrat*, July 7, 1968.

A Doctor Who Served

The "Hippocratic oath," which doctors generally take upon receiving their M.D. degrees, pledges them to a life of service. In the main, they serve as individuals, and the appreciation for their service is voiced primarily — though deeply —by the individuals and families whose pains they relieve. But there are those who, while devoted to that person-to-person help which is the essence of medicine, also find

time as well for public service.

Such a one was Dr. Thomas J. Senese, who died Sunday.

Under three mayors, Dr. Senese served as president of the Gary Health Board, a sometimes irritating job, but one of considerable importance.

So the sympathy of the city should be coupled with that which the many patients and their families will be expressing to the Senese family in their loss. Service, individually or to the public, is what tends to set many doctors apart from many in other professions. Dr. Senese was a notable example of that quality.—*Gary Post-Tribune*, July 23, 1968.

Lesson in Retrenchment

New York State's retrenchment in its lavish Medicaid program carries its little lesson.

After the Federal Government offered to pick up half the cost of such programs, New York passed a Medicaid bill with the nation's most lenient eligibility provisions. Free medical benefits, for instance, went to any family of four making less than $6,000 a year. Though not everyone eligible signed up for the program, it could have covered 5.7 million people or about a third of the state's population.

Not surprisingly, costs got entirely out of hand. The program would have cost over $900 million in the next fiscal year if no reforms had been made. The costs struck hardest in the upstate counties where $6,000 a year is not exactly a marginal income. To pick up their share of the tab, nearly a third of the state's counties had to enact new sales or property taxes.

Also not surprisingly, the Federal Congress decided this sort of program wasn't what it had in mind when it passed its Medicaid provisions. It thereupon enacted amendments to the effect it would no longer maintain its open-ended support of programs like New York's.

So despite protests, most notably from New York City's mayor, the state legislature cut back. It dropped the eligibility level to $5,300, which is still $1,000 above the second most generous state. It also decided that for any wage-earner between the ages of 21 and 65, the state would cover only "catastrophic illnesses," involving the expenditures of 25% of the individual's annual income. These provisions are expected to lower the total cost by about $300 million a year.

The necessity to cut back shows quite clearly what the original bill entailed. It was not aimed merely at actual necessity, at insuring that money would be there to provide medical care for those who would not otherwise receive it. Rather, it attempted to ease the burden on those who could afford normal medical care but only at a noticeable sacrifice.

Eliminating life's painful inconveniences for those who suffer somewhat more than their share, of course, is a laudable enough goal in principle. Yet in practice there is a certain depressing note in European experiences with the psychological and sociological effects of cradle-to-grave security. Beyond that, New York's experience suggests again that practical dollar-and-cents considerations limit how much of life's burden the Government can assume.

The ability to distinguish true necessity from serious inconvenience it seems, is the difference not only between a compassionate society and a welfare state, but also between responsible budgeting and reckless governmental spending.—*Wall Street Journal.*

How Poor Is Poor?

An interesting little item in the July 2 *Washington (D.C.) Daily News* says that the Transportation Department, in a lengthy report, plans to study free auto repair and free public transportation for poor people forced to drive aging unsafe cars to hold a job.

The department pointed out that many unsafe and aging cars are owned by low income wage earners. To offset this the poor wage earner would be given a choice between private and public transportation in getting to work. One of the points to be weighed, the item said, is free auto repair for the low salary worker.

May we be among the first to get in line? Like a good many others our wages are earned, it seems, more for the benefit of bureaucracy and its grandiose programs than for ourselves. How many taxpayers do you know who drive aging automobiles because there simply isn't enough money after taxes to pay for the complete overhauls that are sometimes needed, although their total tax bill is enough annually to pay for a brand new car?

How many taxpayers do you know who drive an aging automobile because they are trying to buy and maintain a home? How many taxpayers do you know whose real estate tax right here in the city of Indianapolis is enough on a per month basis that it would make the payment on a newer car?

How many taxpayers and wage earners do you know who drive an aging automobile because they are trying to put their children through college without benefit of a government (taxpayer) subsidy?

If a department of the United States government is seriously thinking of a subsidy to provide auto transportation (in a repaired car) for those it considers to be low wage earners, then how about the same for those POOR taxpayers who also cannot afford to drive a car that is new or even repaired as it should be?

Or, while they are at it, why don't they propose free repair for color television sets owned by the "poor" at the expense of those who can afford only black and white?—*Indianapolis Star*, July 10, 1968. ◀

It's almost as if you were there to give an injection of penicillin

dependable oral penicillin therapy V-Cillin K®, Pediatric

Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567A] 800197

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206

Lilly

The Journal of the INDIANA STATE MEDICAL ASSOCIATION
Supervised by THE COUNCIL
Volume 61 — October 1968 — Number 10

Ambulatory patients who can travel at all can travel more comfortably and with less exhaustion by air. Consideration of specific diseases is given.

Medical Considerations for Patients In Commercial Air Travel

ROBERT B. STONEHILL, M.D.*
RAYMOND H. MURRAY, M.D.**
Indianapolis

AIR travel as a means of mass transportation has become increasingly popular. In 1958, there were 49 million passengers traveling on scheduled airlines in the United States.[1] In 1965, there were over 84½ million passengers,[2] and it has been estimated that by 1975 there will be over 366 million passengers transported yearly.[3] Armstrong has estimated that three percent of airline passengers are ambulatory patients.[4] Thus, a significant number of patients do travel by this means.

Is this an important problem? In 1965 United Airlines flew 18 million passengers with only 167 in-flight emergencies reported due to illness.[3] How many illnesses went unreported or manifested themselves subsequent to debarkation, of course, is unknown. Also, the death rate in flight was 2.6 per million passengers during the period of 1961 through 1965.[3]

More and more patients are turning to their physicians for an evaluation of their ability to fly. We physicians must be able to give an informed opinion. This article will attempt to highlight reasonable guidelines for safe air transportation.

Area of Difficulty

Two major airlines have had a unique opportunity to transport patients. The Alaska Division of Pan American World Airways often evacuates patients because of the geographic conditions prevalent in that area. Northwest Airlines frequently carries patients to and from the Mayo Clinic and transported over 13,000 patients in a single year.[5] Both of these companies have conducted surveys which aid in our understanding of air travel for patients.

It has become apparent that most patients make excellent travelers. However, there are four principal areas of difficulty: (a) Pressure alterations with ascent to altitude; (b) decreased concentration of oxygen at high altitudes; (c) anxiety and (d) air sickness.

The barometric pressure is progressively decreased as one attains greater altitude. At sea level the barometric pressure is approximately 760 millimeters of mercury (mmHq). As ascent is made, this pressure drops so that at 10,000 feet it is 523 millimeters of mercury and at 18,000 feet it is 380 mmHq or about one-half of the pressure at sea level. In modern aircraft this pressure drop is partially counterbalanced by the artificial atmosphere created in a pressurized cabin. Here the air is compressed so that it will more closely approximate ground level pressure than the atmosphere through which the plane is flying. Pressurization has been so successful that jet aircraft can now fly as high as 23,000 feet while the cabin pressure remains at sea level. At cruising altitudes of

* Professor of Medicine, Indiana University School of Medicine, Indianapolis 46202.

** Professor of Medicine, Indiana University School of Medicine, Indianapolis 46202.

43,000 feet, cabin pressure is equivalent to that at 8,000 feet[6] (so-called cabin altitude).

As barometric pressure decreases, gases contained within body cavities expand. Thus a patient with a closed intestinal segment or pneumothorax may have serious difficulty. The concentration of gas molecules in the atmosphere is proportional to the barometric pressure. As one ascends, he encounters less pressure and therefore a decreasing gas concentration. Oxygen constitutes approximately 21% of the atmospheric gases and has a partial pressure of 160 millimeters of mercury at ground level. Normally, over 95% of the hemoglobin is oxygenated. At an altitude of 8,000 feet the oxyhemoglobin saturation is slightly over 90% and at 20,000 feet it falls to 65%. The body attempts compensation in the normal person through hyperventilation and an increase in cardiac output in an attempt to increase the oxygen available to the tissues. Compensation is adequate in normal persons up to 10,000 feet. However, it is impaired in patients suffering from (a) significant lung disease; (b) cardiac failure; (c) significant anemia and (d) histotoxic states such as insulin shock.

Anxiety, Air Sickness

Anxiety inherent in travel, and especially in air travel, can itself contribute to patient discomfort. It has been shown that the work of the heart increases only slightly by exposure to cabin altitudes used in commercial air travel.[7] However, anxiety can significantly increase the cardiac work load. Probably the best deterrent to excessive anxiety is a strong physician-patient relationship and the confidence instilled by the physician that the patient can make the trip uneventfully. Occasionally mild sedation prior to boarding the aircraft is indicated.

Air sickness is a form of motion sickness with distressing manifestations of nausea, sweating, headache and vomiting familiar to many of us. For certain patients this may be deleterious; for example, the diabetic who cannot afford the loss of calories and electrolytes or the patient who travels soon after abdominal surgery. There are many factors contributing to air sickness besides the motion itself. One of these is anxiety and the relief of anxiety helps to prevent the development of these distressing symptoms. Antiemetic medications such as cylizine (Marezine), dimenhydrinate (Dramamine), meclizine (Bonine) or scopolamine (Hyoscine), are quite effective in preventing this disorder and should be taken at least 20 minutes prior to embarkation along with a light meal. The higher operational altitudes of today's jet aircraft minimize the effects of turbulence secondary to weather, and will usually decrease the tendency towards air sickness.

General Considerations

The patient's condition must be such that he will demand little more attention from the cabin crew than the usual passenger. If he cannot fulfill this requirement, he must be accompanied by an attendant with whose help he will qualify in this respect. His condition must not be personally offensive to fellow passengers, e.g., malodorous or nauseating. He must not be a source of danger to the security of the passengers, e.g., an aggravated psychotic patient, or of contagion to those confined with him in the close quarters of the aircraft. Minimal first aid is available to him at the hands of the crew members. However, emergency medical care generally is as remote as the medical facilities close to the nearest airport where he can be debarked.

Now let us consider specific diseases.

Hematologic Disorders—The presence of a reduced amount of hemoglobin available to convey oxygen to the tissues can be marginally sufficient at sea level. However, the reduced oxygen tensions of high altitudes may cause tissue anoxia in these patients. Thus, a reduction of hemoglobin to less than 50% of normal values or reduction of the red cell count to below 2,500,000 cells per cubic millimeter are relative contraindications to exposures to jet aircraft altitudes. If a transfusion is given to raise the erythrocyte and hemoglobin levels, the trip should not be made for 48 hours after the transfusion.[8] One hematologic problem peculiar to high altitudes is the sickling phenomenon present in approximately seven percent of Negroes. Splenic infarction has been reported as sickling becomes clinically overt at the reduced oxygen tensions of high altitude. Thus, the presence of sickling is a contraindication for severe altitude exposure, and patients should not be subjected to jet flights where the cabin altitudes reach 8,000 feet. They probably should be restricted to propeller-driven aircraft flights where the cabin altitudes are significantly lower. Patients with leukemic disorders can travel by jet aircraft safely if the red blood cell count and hemoglobin determinations are within acceptable levels or are transfused to these levels.

Lung Diseases—The consideration of disorders of the lung centers mainly around the functional ability of this apparatus. Since physiologic hyperventilation is the main compensatory mechanism to altitude exposure, an estimate of the patient's ability to hyperventilate within reasonable comfort levels is important. He should be comfortable, at rest in a sitting position, and be able to increase his respiratory work load by such activities as climbing a flight of stairs with reasonable ease. Cyanosis, respiratory acidosis and cor pulmonale are signs of severe pulmonary disease. While the presence of these signs is not an absolute contraindication to low cabin altitude exposure which may occur in some reciprocating-engine aircraft,

they warn of potential difficulty at the cabin altitudes of 7 or 8,000 feet which can be expected in jet aircraft today. In patients with severe chronic obstructive pulmonary disease, the use of supplemental oxygen is not recommended because of the dangers of significant carbon dioxide retention. However, in patients with mild obstructive pulmonary disease and purely restrictive functional disorders, such as the postresectional state or pulmonary fibrosis, acidosis is uncommon and the patient could use supplemental oxygen and therefore qualify for the higher cabin altitude exposures. Most airlines will provide supplemental oxygen if arrangements are made prior to ticketing. Acute pathologic pulmonary processes, such as acute pneumonia or an asthmatic attack, necessitate postponement of the flight until the condition no longer exists.

Heart Disease—Two factors are of major importance in the evaluation of patients with cardiovascular disease: (1) the increase in the work load on the heart, (2) myocardial hypoxia. There is ample evidence that there are no important changes in heart rate, blood pressure or cardiac work load at the usual cabin altitude (up to 8,000 feet) in normal subjects or patients with mild cardiovascular problems. Above 10,000 feet (the maximal ceiling for nonpressurized aircraft) there are moderate but significant circulatory changes and increase in cardiac work.[7] Individuals with any significant degree of heart disease probably should not be exposed to cabin altitudes over 8,000 feet. In advanced coronary artery disease with severe or unstable angina pectoris, the hypoxia associated with jet aircraft flights is generally contraindicated unless supplemental oxygen is used. Moderately advanced or advanced heart failure or untreated heart failure as well as unstable arrhythmias and severe cerebral or peripheral vascular disease are generally contraindications to travel of any sort, including commercial aircraft travel. In general, the old adage of aviation medicine remains useful; if the cardiac patient can climb a flight of stairs and walk a city block without significant symptoms, he can fly. Careful individual assessment of the patient must be made to ascertain his functional capabilities. Arrangements with airline medical departments are most desirable before any flight in order to assess the projected maximum cabin altitude and to aid the patient in the rigors of airport activities while embarking or deplaning. At this time arrangements can be made for supplemental oxygen if it is deemed necessary.

Abdominal Conditions—The expansion of trapped gases constitutes the main danger here. In a patient with bowel obstruction, gas expansion could compromise the blood supply of the containing bowel wall, with danger of necrosis and rupture. Unreduced hernias must also be viewed with suspicion. A perforated viscus is obviously an absolute contraindication to air travel. The flatulence of patients after abdominal surgery is well known; thus, an air trip should be postponed until at least two weeks after such a procedure.

ENT Problems—Gases will escape from the middle ear and sinuses on ascent to altitude. In a patient with congestion and edema of the nose, as in an upper respiratory infection, difficulty may occur on returning to ground level because of the insufficient capacity for readjustment of air pressure in these spaces. Pain secondary to "aerosinusitis" and "aerotitis media" can be most discomforting. Ordinarily one should not fly with an upper respiratory infection. If air travel is necessary, nasoconstrictors should be used and the patient should chew gum or yawn during descent in an attempt to keep open the Eustachian tubes.

Pregnancy—Pregnant women may fly without question during the first seven months of an uneventful pregnancy. They can fly during the eighth and ninth month if they furnish a statement from the attending physician that they are not due to deliver within five days of their departure from the aircraft.[9] Experience has shown that commercial air travel has caused no detrimental effects to pregnant women.

Infants—It is usually advisable for infants delivered at term not to fly at less than seven days of age because of the immaturity of their respiratory apparatus. Nursing of infants during the descent in flight helps to maintain the patency of their Eustachian tubes and prevents aerotitis media.

Contagious Diseases—Patients with the more serious contagious diseases, such as diphtheria, measles, mumps, whooping cough, scarlet fever and tuberculosis are regulated in air travel as in other travel involving interstate traffic. They come under the jurisdiction of the foreign quarantine service of the United States Public Health Service and are not acceptable for air travel at any time.[10]

Summary

Approximately three percent of airline passengers are ambulatory patients. As the popularity of air travel increases, more and more ambulatory patients will fly. They should and will turn to their physicians for advice. In evaluating such a patient, the physician should formulate an opinion of the patient's ability to travel by air utilizing the equipment and technics available to him in office practice. With few exceptions, the medical problems peculiar to air travel are similar to medical problems in general. An understanding of these will greatly aid in evaluation of the patient. Most patients who can

travel at all, can travel by air more comfortably and with less exhaustion.

BIBLIOGRAPHY

1. Air transport facts and figures, ed. 20, Air Transport Association of America, Annual Report, Washington, D.C., 1959, p. 4.

2. Certified Route Air Carriers — Selected Traffic and Financial Statistics — Fiscal Year 1965, Office of Management Services, Data Systems Divisions of the Federal Aviation Agency.

3. Kidera, G. J.: Clinical aspects of commercial aviation medicine, *JAMA* 201:96, July 24, 1967.

4. Armstrong, H. G.: Air travel and ambulatory patient, International Forum, Vol. 4, No. 1, *Therap. Notes* 63:13, 1956.

5. McFarland, R.: *Human Factors in Air Transportation: Occupational Health and Safety*, New York, McGraw-Hill Book Company, Inc., 1953.

6. (a) Convair Traveler, Monthly Digest from Customer Service Department of Convair 10:8, 1958 (b) Lippert, S.: Engineering approach to human factor problems of jet aircraft, read before Panel on Jet Age and Chest Medicine, 24th Annual Meeting of American College of Chest Physicians, San Francisco, 1958.

7. Grollman, A.: Physiological variations of cardiac output of man: effect of high altitude on cardiac output and its related functions: account of experiments conducted on summit of Pikes Peak, Colorado, *Am. J. Physiol.* 93:114, 1930.

8. Berry, C. A.: Transport of patients by air: what general practitioner should know, *Texas J. Med.* 54:11, 1958.

9. Local and Joint Passenger Rules Tariff, No. PR-4, and Aeronautics Board No. 43, rule 3, article III A, Washington D.C. Air Traffic Conference of America, March, 1958.

10. U. S. Public Health Service, Interstate Quarantine Regulations, Washington, D.C., June 1947; amended March 5, 1967. ◄

From *The Journal* 50 Years Ago

The alarming prevalence of pneumonia in both endemic and epidemic form raises the question of the necessity of quarantining pneumonia cases. There is no doubt that the number of pneumonia cases can be limited through isolation of every case of pneumonia as soon as it develops.

* * *

The Journal of the AMA calls attention to the value of nuts as food and states that the exigencies of war removes nuts from the category of luxuries and places them on the list of substantial components of the day's ration. Comparing bulk for bulk, nuts belong among the most nutritive of foods ordinarily available, and contrary to the generally accepted belief, they are not any more indigestible than other foods rich in protein and fat. They should be used in the diet as are eggs, meats and other foods rich in protein, and they have a physiological value on a par with that of more common staple articles of the diet.

* * *

Government ownership has been a sweet morsel to twist around the tongue of the socialists and other Utopian dreamers, but we believe that the present experience will go a long way toward changing the opinion of those who really use their brains. With government control of railroads, express, telegraph and telephone, we not only are paying more for the service but getting the worst service that the country ever has experienced, and this in the face of increased revenue for those utilities and the boasted efficiency of consolidations and standardization of methods. There is no question about the advisability of regulating public service corporations, but when we operate them under government ownership, with politics as a guiding star in their operation, we open the way for extravagance and inefficiency, and we also do away with the competition that makes for better service . . . . Editorial Notes, *JISMA*, October, 1918.

ACHROMYCIN® WORKS HERE
TETRACYCLINE

Effectiveness: ACHROMYCIN Tetracycline is a crystalline broad-spectrum antibiotic which provides effective therapeutic activity against susceptible microorganisms.

Contraindication: History of hypersensitivity to tetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Some patients may develop a photodynamic reaction to natural or artificial sunlight. Those with a history of photosensitivity reactions should avoid direct exposure to sunlight while under treatment. Discontinue drug at first evidence of skin discomfort.

Precautions: Use may result in overgrowth of nonsusceptible organisms. Constant observation is essential. If new infections appear, take appropriate measures. Use of tetracycline during teeth development may cause discoloration of teeth.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity reaction, onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose-related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels have been reported following full therapeutic dosage. This symptom has disappeared rapidly when drug is discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. Tetracycline may form a stable calcium complex in bone-forming tissue. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: One Gm. per day, in 4 divided doses of 250 mg. each. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

ACHROMYCIN® WORKS HERE
TETRACYCLINE

Actually ACHROMYCIN works wherever the infection is due to an organism your lab cultures have shown to be tetracycline-sensitive. No other tetracycline—or analogue—can assure you of quicker or more effective antibiotic action. After all, isn't that what you want for your patient?

ACHROMYCIN was a pioneer in tetracycline therapy. Seventeen years of experience have shown that when the respiratory system, the genitourinary system, or the skin and soft tissue require treatment for infection probably caused by any of a number of sensitive strains, ACHROMYCIN is a wise choice for therapy while awaiting test results.

Available in 31 useful forms to meet your situational needs.

ACHROMYCIN® V
TETRACYCLINE CAPSULES

The cost differential—inconsequential

Lederle
LEDERLE LABORATORIES
A Division of
American Cyanamid Company
Pearl River, New York 10965

Blunt trauma of the arteries may produce obstructive lesions. Early examination of peripheral pulses and determination of blood pressure in all extremities provides early diagnosis and permits early surgical correction with optimal results.

Arterial Lesions Due to Blunt Trauma

JOHN L. GLOVER, M.D.
CHARLES A. WALTZ, M.D.
HAROLD KING, M.D.
*Indianapolis**

ALTHOUGH penetrating trauma is obviously the most common cause of arterial injuries, blunt trauma is equally capable of producing them. Consequently, it is important that any injured patient be examined carefully for such a lesion, since its successful management depends on prompt recognition and treatment. This report is intended to emphasize the occurrence of this entity by describing the clinical features of five cases encountered during the past year and a half.

Case Reports

Case No. 1: A 23-year-old male sustained a fracture of the right femur in an automobile accident. He was treated at his local hospital by immobilization and skin traction for two days and then transferred to the Indianapolis Veterans Hospital for evaluation. A Steinmann pin was inserted in the tibia on the day of admission and subsequent x-rays showed improvement in position of the fragments.

Two days later the right leg suddenly became pale and painful, with impaired motor function. Pedal pulses were no longer palpable and exploration of the artery was advised. The artery was intact but occluded at the fracture site. A 3 cm. segment was resected and the defect bridged by a saphenous vein graft. Circulation in the leg was reestablished, as shown by the arteriogram taken in the operating room and by the return of pedal pulses (Figure 1). A rent present in the femoral vein near the fracture site was repaired also. The fracture was reduced and fixation was effected by means of an Eggers plate. A spica cast was used for immobilization. Pulses were restored at once, but motor function returned more slowly.

FIGURE 1
OPERATIVE arteriogram after interpolation of vein graft in Case No. 1. A silver clip marks the site of the distal anastomosis.

Comment

There was no question that circulation was adequate initially and did not become insufficient until four days after injury. It is possible that occlusion was present soon after the fracture and that the pedal pulse present on admission was the result of good collateral circulation which later became impaired in some manner. It is more likely, however, that an intimal tear was present initially but did not produce thrombosis until later.

Case No. 2: A 52-year-old white female was injured when the automobile she was driving collided with a truck. After examination at a local hospital, she was referred to Indiana University Medical Center because of pain about the face. She had a fracture of the mandibular anterior alveolar bone, a contusion of the left cheek and several small intraoral lacerations.

There was a contusion and large hematoma on the medial aspect of the right arm. Although the right axillary pulse was present, no distal pulses were palpable. The right hand was cooler than the left but unquestionably viable. There was no neuromuscular deficit.

Exploration of the right brachial artery was performed under local anesthesia about seven hours after the accident. The vessel was intact.

* From the Department of Surgery, Indiana University Medical Center, Indianapolis 46202.

FIGURE 2

PREOPERATIVE angiogram in Case No. 3, showing occlusion of the brachial artery just beyond the circumflex humeral branch.

but an area of marked contusion was encountered at approximately the junction of the middle and lower thirds of the arm. The contused area was well localized and about 15 mm. in length. Complete occlusion was present at this point. After excision of the contused segment, an end-to-end anastomosis was performed, with immediate restoration of distal pulses.

The postoperative course was uneventful. No sensory or motor deficit was present and excellent radial and ulnar pulses have persisted.

Comment

X-rays of the arm showed no evidence of fracture or dislocation and the chest film was normal. The resected segment of artery showed fragmentation with loss of normal architecture. There was a large amount of hemorrhage in the wall and the lumen was filled with fresh clot.

In this patient, initial attention had been given to the head trauma which was really not severe. Although the small alveolar fracture necessitated some dental extractions at a later date, there were no lacerations that required suturing, no major fractures and no signs of intracranial injury. The presence of hematomas on the chest wall and arm alerted the oral surgeon to the possibility of other injuries and a surgical resident readily made the proper diagnosis. Although viability of the extremity was never in question, there is little doubt that reconstruction was indicated.

Case No. 3: A 51-year-old white male railroad worker fell forward with his left arm extended and dislocated his left shoulder. His local physician confirmed the diagnosis by x-ray and, noting no fractures, reduced the dislocation easily. Having recognized that no radial pulse was present before or after manipulation he referred the patient to the Indiana University Medical Center.

Upon admission, six hours after injury, the patient complained of a numb left hand which he could not move. There was no motor function below the left deltoid, and anesthesia extended to the elbow. There was an ecchymosis in the axilla. A subclavian pulse was present, but no arm pulses could be felt. The left arm was cool and slightly mottled below the midbrachial level, but good capillary filling was present.

The functional deficit was felt to be secondary to brachial plexus traction. Since the arm was definitely viable and there was evidence of increased vasomotor activity, a sympathetic block was performed, with resultant increase in warmth and venous filling and in the appearance of a weak radial pulse. Accordingly, immediate exploration was not advised and a program of physical therapy was begun as well as continued sympathetic blocks.

Although motor and sensory function returned slowly during the ensuing three weeks, the radial pulse remained very weak. Arteriography revealed a 3 cm. segment of occlusion of the left brachial artery just distal to the circumflex humeral artery and reconstruction was advised (Figures 2 and 3).

At exploration, the artery was intact, but occluded just distal to the origin of the circumflex humeral branch for a distance of about 3 cm. The operator elected to bypass the obstruction, using a segment of saphenous vein. Distal pulsatile flow was re-established but disappeared several hours after the procedure, necessitating re-exploration. Revision of an area of intimal dissection at the distal anastomosis re-established flow permanently (Figure 4).

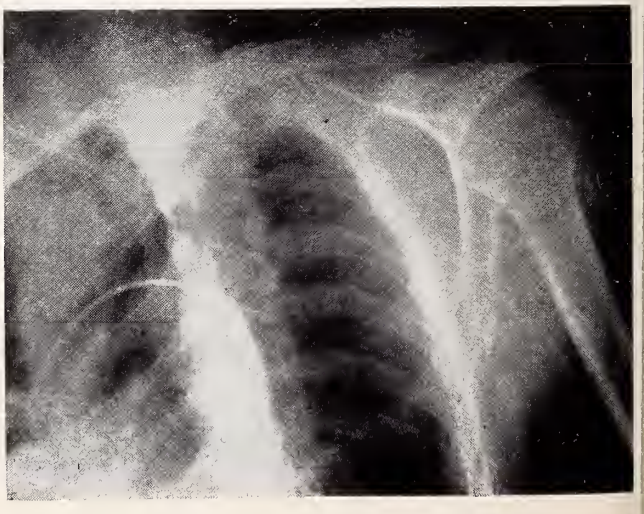


FIGURE 3

LATER film in Case No. 3, showing filling of the distal brachial artery by collateral circulation.

The patient remained well and has returned to work. A very slight biceps weakness was still present six months after operation. Blood pressure in the arms was equal.

Comment

Although immediate anatomic findings are not available, it seems apparent that the lesion was thrombosis in an area of intimal disruption. The weak pulse that appeared was undoubtedly the result of this laborer's good collateral circulation. Ischemia at rest, therefore, was not a problem and reconstruction was delayed until it became evident that the neurological lesion was improving and that he would have a useful arm.

FIGURE 4
POSTOPERATIVE angiogram in Case No. 3. The patent vein graft bridges the area of obstruction.

Case No. 4: An 18-year-old white male was taken to his local hospital in shock after an automobile accident. Immediate resuscitative measures were begun and he improved rapidly. A traumatic amputation of the distal phalanx of the left fifth finger was debrided and closed. The following morning, however, it was noted that the left hand was ischemic; arrangements were made to transfer the patient to the Indiana University Medical Center.

Upon admission. he was conscious and oriented, and there was no sign of intracranial injury. There was a large left supraclavicular hematoma, but there was no clinical or x-ray evidence of fracture or dislocation involving the clavicle, scapula or humerus. The left carotid pulse was normal, but a subclavian could not be identified. The left arm was flail, anesthetic and pulseless. The thumb and fifth finger were cold and blue, with no capillary filling. The tips of the remaining digits had a similar appearance and the hand was dead-white. The lower two-thirds of the forearm was cool. Arteriography revealed obstruction of the subclavian artery beyond the origin of the thyrocervical trunk. There were multiple pelvic fractures, which accounted for the shock immediately after injury.

Although most, if not all, motor and sensory changes were thought to be secondary to brachial plexus injury, an attempt at revascularization seemed advisable to prevent further tissue loss. About 24 hours had elapsed between the accident and operation. Exposure of the subclavian artery was facilitated by resection of the medial third of the clavicle, as described by Shumacker.[12] The artery had been transected about 10 mm. beyond the thyrocervical trunk and the proximal end was filled with thrombus. The humeral and coracoid attachments of the pectoral muscles were divided to locate the distal end of the artery, which also was occluded by thrombus. The contused ends of the vessel were resected, and continuity was restored by interpolating a segment of cephalic vein. Good flow was established.

In dissecting the proximal subclavian vessel, it was apparent that the entire brachial plexus had been avulsed from the spinal cord, with the intradural roots lying free in the supraclavicular fossa. After operation the circulatory status of the forearm markedly improved, but, as expected, the hand did not. Amputation was performed at the distal humeral level four days later. Although his convalescence was complicated by perforation of a duodenal ulcer, his recovery was ultimately complete and he has learned to use an arm prosthesis.

Comment

This patient was injured so severely that he might have died if his initial treatment had not been vigorous. The delay in recognition of the arterial injury did not affect this patient's final result, but might have done so in a patient with a brachial plexus injury similar to that in Case No. 3.

Case No. 5: A 51-year-old laborer was struck by an automobile moving in reverse. A rear wheel passed over his right groin. The physician who saw him in the local accident room noted the presence of a large groin hematoma and the absence of lower extremity pulses. Pelvic fractures were also present.

Upon admission to Indiana University Medical Center soon thereafter, his right foot was cool, anesthetic and motionless. He was taken to the operating room immediately, and the external iliac artery was found to be thrombosed in its distal portion at an area of intimal disruption. Although a 4 cm. length of artery was resected, an end-to-end anastomosis was possible because of the pliable vessels and the great mobility of the extraperitoneal iliac vessel. Excellent pedal pulses were re-established and the remainder of his recovery was uneventful.

Comment

Early recognition of the arterial injury was undoubtedly a major factor in the ease of his convalescence.

Discussion

Although the technic of blood vessel anastomosis was described by Carrel in 1905, ligation was still the accepted procedure for all but 81 of the 2,552 acute arterial injuries in World War II reported by DeBakey and Simeone.[2] Since the amputation rate was nearly 50% in those treated by ligation, the better results (36% amputation) in the small series treated by lateral repair stimulated the interest of surgeons in the Korean conflict; and it soon became apparent that reconstruction offered a far greater rate of limb salvage than previously deemed possible.

Although the war trained a number of surgeons to handle vascular problems, the rising number of accidents and altercations of civilian patients necessitated continued interest in the subject, as indicated by Morris' report of 136 cases in 1957.[8] While the majority of the injuries were associated with penetrating or perforating wounds, reports of arterial damage in blunt trauma began to appear. Laceration or complete disruption was usually associated with fracture or dislocation, but intimal fracture was also incriminated as a cause of thrombosis in such injuries.[1,3,7,8]

The major arteries to the limbs are so close to the long bones that it is surprising that fractures and dislocations are not more commonly associated with vascular damage. Indeed, it is becoming apparent that certain injuries, such as dislocation of the knee, frequently are complicated by circulatory interruption. Seven of Kennedy's 22 cases required popliteal artery exploration and only two of the limbs were saved![5] Peltier, quoting an incidence of 50%, does arteriograms in every case of knee dislocation to rule out arterial injury.[9] While this may seem unnecessary, it may be justified by the very low recorded rate of limb salvage in popliteal artery injury.[4,13] Certainly if any question of ischemia persists after successful reduction, investigation is mandatory.

Fracture of the shaft of the femur, as in Case No. 1, is an important, though less frequent cause of arterial injury in the leg. Instability of the fracture may jeopardize the vascular repair, and fixation is advised if feasible.[6,9]

The most common arterial injury in the arm is axillary artery occlusion associated with dislocation of the shoulder. The mechanism was shown clearly by Kennedy in 1958.[5] Having had two cases of this lesion, he did arteriograms on cadavers before and after shoulder dislocation and was able to show the axillary artery stretched taut over the humeral head at the level of the subscapular branch. Other authors have confirmed this location of the occlusion, as did our Case No. 3.

Case No. 4 had no dislocation of the shoulder when seen, but the mechanism of his injury must have been a similar one. Spontaneous rupture of the axillary artery has been reported, however, by St. John.[11] Although his patient apparently had an arterial anomaly or disease, he quotes a case reported by Koch in which weight-lifting apparently caused the rupture.

Case No. 2 illustrates the ability of a direct blow to cause arterial occlusion, apparently with intimal fracture the basic cause. This is quite similar to Rob's two patients, each of whom sustained a blow from a sharp edge directly over the brachial artery.[10] Such instances must be relatively rare and a more diffuse force of this severity would usually also cause a bone injury.

The key to successful management is early recognition of the injury. We have the feeling that "spasm," "vasoconstriction," and "sympathetic overactivity," though undoubtedly active in certain situations,[14] are asked to bear more than their share of the blame for the presence of cool extremities in injured patients.

Case No. 3, for example, must have had occlusion within a few hours of injury but was initially thought to have vasospasm because of the presence of a weak radial pulse. Although observations on the quality of *one pulse* in such a limb and on the skin color and temperature are quite important, there is no substitute for the careful recording of the presence or absence of *all pulses* and, unless physically impossible, the *blood pressure* in the involved and contralateral limb. If this is done by the first physician who sees the patient, it is of great advantage to those responsible for his subsequent management.

If the location of occlusion or disruption is important in determining the operative approach or if there is reasonable doubt as to their existence, arteriography should be done as an emergency procedure. If a lesion is present, correction must be done at once if viability is in question.

Although restoration of continuity by end-to-end anastomosis is preferred, the defect is frequently long enough to require a graft. In such instances an autogenous vein is recommended, though there are situations which require use of a cloth prosthesis. Sympathectomy is usually not necessary.

If the injury is one in which there is reasonable likelihood of arterial damage but the original examination indicates intact circulation, the physicians caring for the patient must continue to be alert for signs of ischemia. Motion of an unstable fracture might cause the injury or, as probably happened in Case No. 1, thrombosis may occur later at the site of an intimal tear.

With proper awareness of this entity, results should be generally quite good. All of our patients had

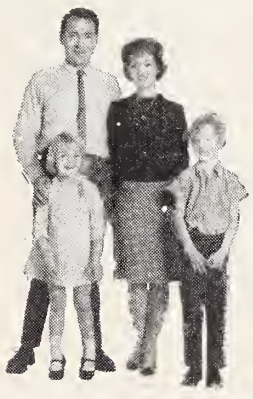
an excellent result except Case No. 4, in which irreversible ischemia had occurred prior to operation. His brachial plexus injury, however, would have ultimately necessitated an amputation even if viability had been restored.

Summary

Five cases of blunt trauma producing arterial damage are described. It is essential that all physicians treating injured patients be aware of this pathologic entity, especially as a concomitant of certain fractures and dislocations. The most important factor in early diagnosis is a careful examination of the vascular status of all the extremities, including recording of all pulses and the blood pressure in all extremities. The proof of vascular integrity in these patients is not satisfied by a clinical impression of arterial spasm. If doubt exists, arteriography should be done; if a lesion is present, it should be repaired.

BIBLIOGRAPHY

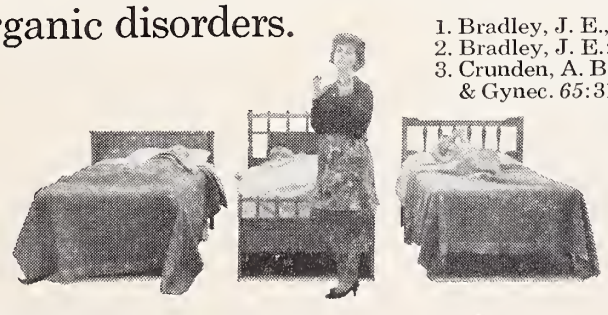
1. Collins, H. A., Jacobs, J. K.: Acute Arterial Injuries Due to Blunt Trauma, *J. Bone & Joint Surg.* 43A:193, 1961.
2. DeBakey, M. E., Simeone, F. A.: Battle Injuries of the Arteries in World War II, *Ann. Surg.* 123:523, 1946.
3. Elliot, J. A.: Acute Arterial Occlusion: An Unusual Case, *Surg.* 39:825, 1956.
4. Hoover, N. W.: Injuries of the Popliteal Artery Associated with Fractures and Dislocations, *Surg. Clin. N. Amer.* 41:1099, 1961.
5. Kennedy, J. C.: Complete Dislocation of the Knee Joint, *J. Bone & Joint Surg.* 45A:889, 1963.
6. Kirkup, J. R.: Major Arterial Injury Complicating Fracture of the Femoral Shaft, *J. Bone & Joint Surg.* 45B:337, 1963.
7. Moore, T. C.: Acute Arterial Obstruction Due to Traumatic Circumferential Intimal Fracture, *Ann. Surg.* 148:111, 1958.
8. Morris, G. C., Jr., Creech, O., Jr., DeBakey, M. E.: Acute Arterial Injuries in Civilian Practice, *Amer. J. Surg.* 93:565, 1957.
9. Peltier, L. F.: Some Complications of Fractures, *Curr. Probl. in Surg*, May, 1967, p. 38.
10. Rob, C. G., Standeven, A.: Closed Traumatic Lesion of the Axillary and Brachial Arteries, *Lancet* 1:597, 1956.
11. St. John, F. B., Scudder, J., Stevens, D. L.: Spontaneous Rupture of Axillary Artery, *Ann. Surg.* 121:882, 1945.
12. Shumacker, H. B., Jr.: Incisions in Surgery of Aneurysms, *Ann. Surg.* 124:586, 1946.
13. Spencer, F. C., Greive, R. V.: The Management of Arterial Injuries in Battle Casualties, *Ann. Surg.* 141:304, 1954.
14. Wray, J. B.: Management of Supracondylar Fracture, *Arch. Surg.* 90:279, 1965.



Togetherness....

...can be rough when epidemics of nausea and vomiting strike a family. Emetrol offers prompt, safe relief. It is free from toxicity[1] or side effects[2,3] and will not mask symptoms of serious organic disorders.

1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



RORER
WILLIAM H. RORER, INC.
Fort Washington, Pa.

Emetrol®
phosphorated carbohydrate solution
emesis control

Geigy

Regroton®

chlorthalidone 50 mg.
reserpine 0.25 mg.

One Regroton tablet a day usually helps you and your patient bring high blood pressure down and keep it down.

Regroton produces a smooth, long-acting effect that usually reduces both systolic and diastolic pressures. At the same time it often acts to allay anxiety and nervous tension associated with hypertension.

Although Regroton is generally well tolerated, adverse reactions may occur. This drug is contraindicated in mental depression, demonstrated hypersensitivity, and most cases of severe renal or hepatic diseases. For a complete list of side effects, please see the Prescribing Information summarized on the following page.

Regroton®

chlorthalidone 50 mg.
reserpine 0.25 mg.

One Regroton tablet a day
usually helps you and your patient
bring high blood pressure down
and keep it down.

Indications: Hypertension. **Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. **Warning:** With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers. **Precautions:** Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000.
(B)46-600-C
For details, please see complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

RE-6225

Infectious mononucleosis is susceptible to routine diagnosis and presents itself as a distinct clinical syndrome. In this double-blind study, no advantage could be demonstrated for therapy with oral enzymes.

Treatment of the Exudative Tonsillar Phase of Infectious Mononucleosis with Oral Enzymes

MAC C. ROLLER, M.D.
Franklin

I recently worked at a university health center where a large number of patients with infectious mononucleosis were treated. I became discouraged by an inability to offer much relief to many students unfortunate enough to develop the severe manifestations of an exudative pharyngotonsillitis during the course of their illness. These individuals were often toxic, febrile and hardly able to talk or swallow.

I watched the response of patients to treatment with antibiotics, throat irrigations, analgesics and steroids. In some, favorable response seemed never to occur; the patient suffering for days in this miserable anginal state. In others, favorable response was noted more quickly. The unfortunate truth, however, was that both satisfactory and unsatisfactory responses occurred independent of the form of treatment. None of the therapeutic methods brought consistently favorable responses.

Double-Blind Study

I reviewed less common methods of treatment and their shortcomings. Steroids, said by some to give dramatic relief,[1-4] failed in my cases to give any consistent clinical respite. Knowing of the claims for the use of oral enzyme preparations in the reduction of inflammation and edema, I empirically tried this form of treatment with my next six patients. I was overjoyed to hear the patients speak of significant and gratifying improvement and to see objective decrease in tonsillar swelling, pharyngeal edema and resolving of the exudate in 24 to 48 hours in each patient.

I was aware that my excitement had to be tempered by such results as Norfleet's study[5] after Gothberg's report of chloroquine treatment.[6] Knowing that in some cases the exudative tonsillar phase is normally quite short, a double-blind study was arranged to evaluate the possible beneficial effects of oral enzyme preparations specifically in the treatment of the pharyngotonsillar phase of infectious mononucleosis.

Patients were selected in this manner:

1. The diagnosis of infectious mononucleosis was established by both clinical and laboratory criteria. Guidelines suggested by Bayrd[7] and Hoagland[8] were followed.

2. In each case, primary subjective and objective clinical manifestations were severe pharyngotonsillar discomfort.

3. All had received no prior treatment.

4. All were in the very early clinical stages of the disease.

Since it has been well established that antibiotics do not affect the course of infectious mononucleosis, throat cultures were obtained on all patients so that any secondary bacterial infections, especially group A beta hemolytic streptococci, could be treated appropriately and concomitantly.

Materials and Methods

The oral enzymes used were the bromelains, a proteolytic enzyme preparation produced commercially. Two tablets four times daily were administered as suggested by the manufacturer. Packaging and coding of the enzyme tablets and the placebos was done by a pharmacist and the coded packages were distributed randomly to the patients. The code was of course not revealed until the entire study had been completed.

In addition to the coded medications, the usual mouth washes and gargles were allowed as well as antipyretics and analgesics. Antibiotics were administered to those patients showing evidence of secondary bacterial infections. No patients were given steroids.

The clinical evaluation of all patients was done by the author. In a previous review,[9] I found the anginal phase of untreated infectious mononucleosis to last an average of 5.1 days. Thus the criterion for a satisfactory response was definite subjective and objective improvement in less time, preferably in 24 to 48 hours. Patients were examined dur-

ing their illness for objective changes and were questioned about their subjective improvement. At the end of the study and before the code was revealed, all data were evaluated and cases were categorized as to response on the following basis:

A—Inadequate follow-up or known to have taken the medication improperly.

B—Satisfactory clinical improvement.

C—Satisfactory clinical improvement tempered by the belief that the response may have been due to a "naturally short" illness.

D—Definitely no clinical improvement.

When all cases in category A were discarded, 82 cases remained. The results are tabulated in Table I.

TOTAL PATIENT PROFILE

	Enzyme	Placebo
Satisfactory clinical improvement.	10	8
Satisfactory response but probable "normal course."	8	15
No clinical improvement.	21	20
Total patients	39	43

TABLE I

The double-blind study thus failed to indicate any clinical benefit from treating the exudative pharyngotonsillar phase of infectious mononucleosis with oral bromelain enzyme therapy. At present it seems that no single satisfactory treatment method has been found.

REFERENCES

1. Breen, G. E., Talukdar, P. K.: Corticosteriods in the Acute Infections, *Lancet* 1:158-160, (Jan. 16), 1965.
2. Bender, C. E., Houghton, B. C.: Treatment of Infectious Mononucleosis with Corticotropin, *Northwest Med.* 52:922-925, (Nov.), 1953.
3. Cronk, G. A., Naumann, D. E.: ACTH, Tetracycline and Tetracycline Combined with Cortisone in the Treatment of Infectious Mononucleosis, *J. Lancet* 76:77-78, (March), 1956.
4. Bender, C. E.: The Value of Corticosteroids in the Treatment of Infectious Mononucleosis, *JAMA* 199:529-531, (Feb. 20), 1967.
5. Norfleet, R. G., et al.: Infectious Mononucleosis Treated with Chloroquine, *Arch. Int. Med.* (Chicago) 113:412-14, (Mar.), 1964.
6. Gothberg, L. A.: Severe Infectious Mononucleosis Treated with Chloroquine Phosphate, *JAMA* 173:53-57, (May 7), 1960.
7. Bayrd, E. D.: Infectious Mononucleosis: Some Considerations in Diagnosis and Treatment, *Med. Clin. N. Amer.* 40:1091-1101, 1956.
8. Hoagland, R. J.: Clinical Manifestations of Infectious Mononucleosis, Report of Two Hundred Cases, *Am. J. Med. Sci.* 240:21-28, 1960.
9. Roller, M. C.: Infectious Mononucleosis, *JISMA* 60:32-35, (Jan.), 1967. ◄

1100 Hillview Dr.
Franklin 46131

A hospital for the diagnosis and treatment of psychiatric illness

WABASH VALLEY HOSPITAL

(a not for profit corporation)

2900 North River Road (State Road 43 north)

West Lafayette, Indiana 47906 Phone 317-743-3841

Active Psychiatric Staff	(Phone)
W. R. VanDenBosch, M.D.	447-6404
David L. Evans, M.D.	447-9155
Joe M. Martin, M.D.	743-1809
Edgar C. Stuntz, M.D.	
Limited private practice	
John H. Wilms, M.D.	
F. H. Spurlock, M.D.	749-2441
Alfred R. Heasty, M.D.	

Robert K. Jones, Ph.D.
Clinical Psychologist

Mrs. Margaret Keedy, A.C.S.W.
Psychiatric Social Worker

Elizabeth J. Snyder, R.N.
Director of Nursing Service

James Jones, B.P.E.
Director of Activity Therapy

Donald R. Kinzer, Hospital Administrator

John Sterzer, Business Manager

Admissions are arranged through referral to any active staff psychiatrist.

All general medical and surgical specialties in the community are available through physicians on the open consulting staff.

Does your assistant need an assistant?

Yes. And she has one. At Blue Shield.

It takes a lot of business know-how to run your office smoothly and still have time to help out in a crisis, or listen to your patients, or act as your aid. It's a big job, and Medicare has made it even bigger.

Your assistant can do it all. But Blue Shield wants to make her job a little easier.

That's why we now have a representative available to come to your office when your assistant needs help in solving a Blue Shield problem.

That's also why we have a series of dinner-workshops each year to meet her specific needs, and why, along with our publications to you, we send the "News Capsule" to your assistant.

So if you want more time to care for your patients, make sure your assistant has an assistant. Blue Shield.

BLUE SHIELD
110 N. Illinois Street
Indianapolis, Indiana 46204

Finally...a salicylate superior to aspirin?

Not at all, Doctor...but magan®

(magnesium salicylate, W-T)

should be considered for your arthritic and rheumatic patients who cannot tolerate aspirin.

Surveys * made in 1966 and 1967 among private practice physicians showed an incidence of intolerance to aspirin ranging from 3-85%. The majority of physicians surveyed reported an intolerance in 10-30% of their patients.

How does this compare with your experience?

*by two independent national research organizations

WARREN-TEED PHARMACEUTICALS INCORPORATED
COLUMBUS, OHIO 43215
SUBSIDIARY OF **ROHM AND HAAS COMPANY**

10-30

Don't use Magan on all your patients–

consider Magan for those patients who cannot take aspirin because of gastric discomfort

Private Practice Physicians tried Magan on almost 700 patients whom they judged intolerant to aspirin and other salicylates.

The majority of these patients could take Magan and obtain the benefit of salicylate therapy.

magan® **an alternate salicylate**

(magnesium salicylate, W-T)

May be tolerated by some persons intolerant to aspirin by reason of gastrointestinal irritation.

Magan is a new salicylate product from Warren-Teed.

A single chemical entity . . . no coating, no buffering, sodium free and non-acetylated.

Composition: Each orange colored tablet contains 5 grains (approx. 325 mg) of magnesium salicylate.

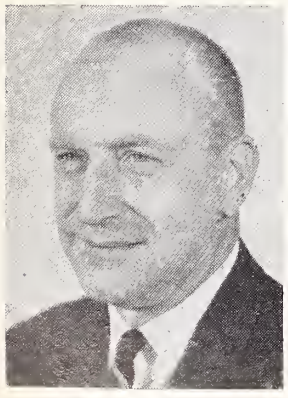
Dosage: 1 or 2 tablets every 4 hours with a full glass of water.

The Management of Depressive States

JOHN I. NURNBERGER, M.D.
Indianapolis*

A RECENT television program portrayed the rich profusion of underwater life to be encountered on a tropical coral reef. The myriad forms of plant and animal life passed in parade before the camera. The focus was now set on a brilliantly striped, innocent appearing Zebra fish whose camouflaged barbs could inject a toxin fatal to man. Attention now shifted to a vicious and aggressive Moray eel, poking its ugly head from a coral burrow. No one could miss its menacing appearance.

The scene changed to the green depths where a blob of umbrella-like matter was billowing its course through the warm water, fragile tentacles trailing behind. Contact with these tentacles transferred a low potency toxin which could cause long-term malaise and lethargy through superficial wounds as inconspicuous as insect bites.



The many facets of depression in man are analogous to this display. Together with anxiety, depression is the most common emotional accompaniment of psychosomatic disorders. It occurs as the central or solitary emotional response in virtually all psychiatric ills. Its somatic manifestations, like those of anxiety, commonly bring the sufferer to the general practitioner, internist, surgeon or gynecologist, not to the psychiatrist. But depression, however commonplace, rarely presents in classic form. The dangerously agitated psychotic-depressive, like the Moray eel, is readily diagnosed, even by the inexperienced practitioner. Approximately 85% of clinically depressed patients do not look nor sound depressed on superficial examination. Their symptoms may be as chronically debilitating and insidious as those which result from contact with the primitive jellyfish, or as unpredictably fatal and final as those which follow the sting of the Zebra fish. One simply cannot judge by appearance.

The alarming incidence of suicide among our adult population justifies great clinical concern. A dangerous behavior which claims the lives of 20,000 otherwise healthy Americans each year, as certified by death certificates, and which, in addition, may well contribute significantly to the deaths of up to 40,000 more, is our urgent business. Suicide and depression are inextricably linked.

Behind Many Masks . . . .

An essential element in the management of depression is the acknowledgement of its presence. Depressed patients may present as inordinately cheerful, tightly smiling, happily martyred, acceptant and self-effacing, fearful (especially of cancer, heart disease or brain tumor), sarcastic, restless, suspicious, generally reassuring, but rarely as hopeless, helpless, worthless, guilt-ridden, and unworthy . . . at least not on first contact. Then how can the diagnosis be confirmed, or its presence revealed?

The most dependable avenue of approach is the simple historical exploration of the somatic-symptom array which accompanies depression in virtually all instances. The depressed individual, whether agitated or retarded, does suffer changes in certain pleasurable biological activities. These include recent changes in bowel function (whether toward diarrhea or constipation), in eating behavior and savor for foods (whether toward compulsive increase in eating with weight gain, or toward loss of appetite with reduced food intake and weight loss).

Additional consistent changes are to be found in sleep pattern with loss of usual refreshment in sleep. difficulty falling asleep, light, disturbed sleep or, occasionally, early morning awakening. Changes in sexual behavior occur, with loss of pleasure in sexual activities (even though the rate and intensity of behavior may be increased) and, less commonly, with reduction or loss in sexual desire, failure or loss of sexual potency in the male, irregularity or termination of menses in the premenopausal female. Physical activity is also commonly affected.

Occasionally weakness, ready fatigue, easy exhaustibility and "lack of energy" are experienced, but quite as commonly, one may note increase in motor activity, restlessness, involvement in "busy work." The key to the process is the presence of significant recent change in any or all these aspects of somatic functioning. Evidence of recent change in at least three of the above five areas of function justifies a strong suspicion of depression, no matter how vigorously the patient may deny its

* Professor and chairman, Department of Psychiatry, Indiana University Medical Center, Indianapolis 46202.

presence, no matter how deceptively cheerful the patient may seem. We must always recall that a central defensive mechanism of depressed patients is *denial*.

A Potential Suicide?

If the history justifies our strong suspicion that the patient is depressed, the next essential step in management is the appraisal of suicidal potential. This must be approached by direct questioning. The patient's first responses must never be accepted at face value. Where suspicion is strong, questioning must be pursued and questions repeated, until the examiner is convinced that serious suicidal potential does not exist. Independent factors which increase the probability of suicide are well recognized. They include a history of previous attempts by the patient, a family history of suicide and recent change in the status of the patient, especially loss or separation from spouse and family and/or loss of vocational security. For the older female, this last might be heralded by the departure of the last grown child from the home.

Certain depressive states seem to be more determined by biological-constitutional factors, and less related to social-psychological ones. This is true of all psychotic-depressive reactions, of depression in the course of schizophrenic illness and of manic-depressive states. In these, presence of delusions (somatic or paranoid), of unrealistic thinking, perceptual distortion and depersonalization point to a psychotic process. The efficient control of psychotic depression usually involves physical methods, whether electric shock, drug therapy, or both.

For moderately severe reactions, Tofranil, Aventyl hydrochloride (more rapid in its initial effects) or Elavil is indicated. For more resistant states, where delusional formation is firmly established or paranoid elements prominent, agents such as Prolixin or Stelazine may be used or occasionally added. Milligram for milligram, the latter two drugs are approximately 25 times as potent as the others. Under even ideal circumstances, a certain number of such patients will fail to respond over a three- or four-week period. The excellent recent review by Heinz Lehmann states that as many as 25% of such patients may not respond satisfactorily to any drug regime. Additional use of electric shock treatment may produce favorable, if sometimes temporary, changes in an additional 15% of such resistant patients, leaving a hard core of approximately 10% who fail to respond. For a few of these showing cyclothymic features (manic-depressive), lithium carbonate treatment should be considered, and also for recurrent manic-elated patients generally.

Of Unconscious Origin

If psychotic manifestations are absent, as in neurotic-depressive reactions and in the depression which accompanies or is a part of such common disorders as essential hypertension, clinical investigation points to the overriding importance of social-psychological determinants in the patient's immediate home environment. Such individuals commonly insist that their depressive symptoms are a result of overwork, financial worry, marital strife, unfavorable work circumstances or guilt-laden moral transgressions. These factors are, in fact, of little or no moment in depression. The sources of depressive guilt have an unconscious, not a conscious origin. Because the typical patient commonly presents with complaints of tension or anxiety, the physician is tempted to prescribe a mild tranquilizer such as Meprobamate or Librium. The temptation should be resisted. Such drugs may induce mild or even significant relief from the accompanying anxiety, but they also accentuate depressive symptoms and should be used with great caution.

The most important ingredient of effective therapy in nonpsychotic-depressive reactions is *time*. The physician must invest the time necessary to permit such a patient to come to know him, to acquire confidence in him, to arrive at the conclusion that the physician is genuinely concerned about and interested in him and his problems. If Tofranil, Elavil or Aventyl hydrochloride are prescribed, as may well be indicated, he will assure markedly better results by prescribing such medications *not* at the first visit, but after several visits when the situation is generally better identified and understood.

In such patients, effective and often definitive psychotherapy must focus on social relationships with the immediate family, especially children, parents and siblings. Depression of this type seems to result from a deep sense of guilt either over murderously angry feelings toward those who should command love (children, parents, siblings) or to guilt over highly unacceptable but generally unrecognized sexual impulses and desires directed toward "tabu" objects. Thus, homosexual and incestuous sexual impulses are of central concern. The physician, whether psychiatrically trained or not, should *never* pursue an exploration of such conflicts in an explicit way and by "name."

The only safe procedure is a systematic review and analysis of the nature and recent history of the patient's attitudes, behavior and re-

actions to important family members.

If matters take such a course that the patient appears likely to identify explicitly his incestuous or homosexual conflicts and he is clearly incapable of tolerating such "insight," as is commonly true, the historical investigation should be terminated or diverted. Such patients should, if possible, be referred to a psychiatric colleague for more intensive and regularly scheduled therapy and follow-up.

Summary

A note of cautious optimism is indicated, in summary. Depressive illness is extremely common. Under certain identifiable circumstances, depression may threaten survival or even cost the patient his life. It is a relatively simple matter for the informed physician to make a confident estimation of this possibility. In the vast majority of instances, with a small investment of time, a conservative use of simple medications and an appropriately focused interest on the family aspects of the patient's life and relationships, any physician should be able to manage successfully in definitive depth all but the most extreme reactions. ◀

About Our Cover

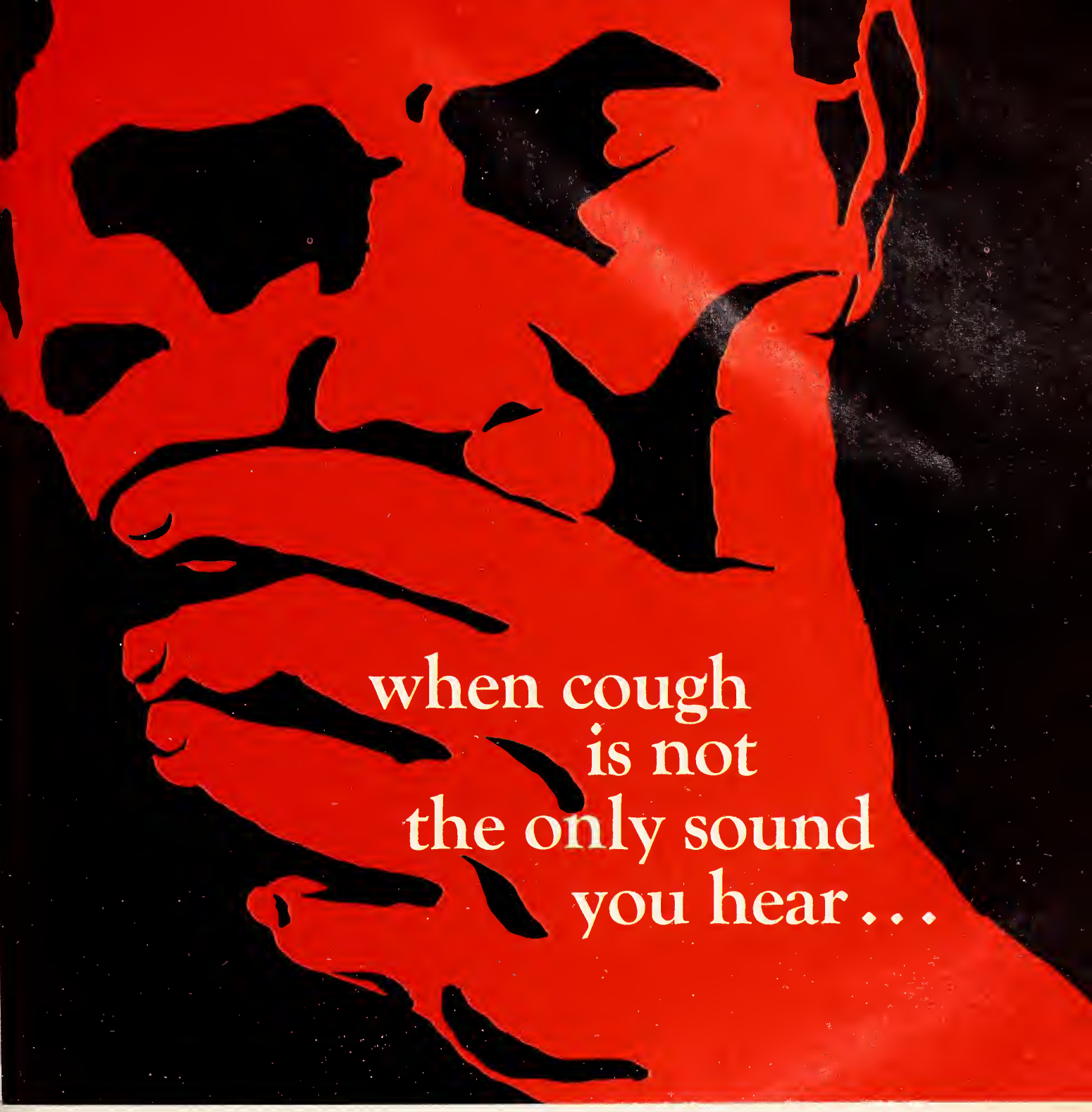
Each new day brings another problem to the office of the general practitioner. With the increased use of air travel by persons all over the world, the general practitioner must evaluate his patients with respect to their physical ability to stand the changes in pressure and altitudes.

This month, *The Journal* begins a series of four articles specifically designed to aid the general practitioner in making these decisions. The first article, "Medical Considerations for Patients in Commercial Air Travel" is a general review of all aspects of flying. The second, entitled "The Evaluation of the Cardiopulmonary Patient for Air Travel," will appear in November and will go into greater detail in the evaluation of the cardiopulmonary patient and his ability to travel by air.

December will bring "Commercial Supersonic Transportation and the Patient," and will be a glance into the future. "The Dangers of Dysbarism," which will appear in January, will consider an aspect of aviation medicine which is little understood by the medical public.

This is an interesting and intriguing series of articles. We hope you will watch for it and that it will help you in evaluating your patients ability to use air travel.

Our thanks to Mr. Frank Bodwell, District Sales Manager for American Airlines, for making this month's cover available to us.--J.F.S.



OMNI-TUSS® b.i.d.

. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.

In the complex picture of moderate to severe anxiety...

there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl) 25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-

on call...
Keflin®
Sodium
Cephalothin
Lilly
Eli Lilly and Company
Indianapolis, Indiana 46206

"The inconvenience of a cold"

For a cold, NTZ® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTZ is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTZ Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

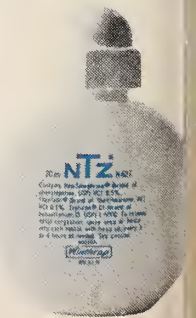
Supplied: NTZ Nasal Spray, plastic squeeze bottles of 20 ml.; NTZ Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

NTZ is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



Winthrop Laboratories, New York, N.Y. 10016 Winthrop

CLINICOPATHOLOGIC CONFERENCE

Discussant: Dr. Roy H. Behnke.

A 67-year-old white married female was admitted to Indiana University Medical Center five hours after ingesting a barbiturate in a suicide attempt. She died three days later with an associated pulmonary insufficiency.

The patient had been ill for many years: Forty years previously she suffered postpartum thrombophlebitis which resulted in a chronically swollen, tender left leg, several episodes of recurrent acute left leg thrombophlebitis and severe stasis dermatitis. For several years the patient had been incontinent of stool, though this symptom had never been investigated. Because of the swollen, painful left leg, the stool incontinence and severe pain and limitation of the movement of the neck and spine (which had been diagnosed as "arthritis"), the patient had been bedridden for seven years. A week prior to admission her pet cat bit her right hand, resulting in pain, erythema and edema of the hand. Her physician prescribed codeine and a broad-spectrum antibiotic.

Terribly despondent, the patient consumed several of the codeine tablets along with a large bottle of 60 mgm phenobarbital tablets, in an obvious suicide attempt. She was taken immediately to her local hospital, where gastric gavage produced a large volume of pink fluid. She was transferred promptly to Indiana University Medical Center. Except for a penicillin allergy, the past history was otherwise unremarkable.

On arrival at the hospital, she was deeply comatose and completely unresponsive to any stimulation. Blood pressure was 125/80; pulse 82; respiratory rate 12/min. and of adequate depth; temperature 97.2 degrees F. The corneal and pupillary reflexes were intact; except for +1 brachioradialis reflexes, the patient was otherwise flaccid and areflexic.

The patient was moderately obese. The left leg demonstrated minimal, non-pitting edema and marked stasis dermatitis. Thrombosed varices were found in both legs. The right wrist and forearm were swollen and warm; obviously inflamed puncture wounds were present on the hand. There was no significant lymphadenopathy in the right axilla or elsewhere.

The remainder of the examination was unremarkable; the fundi were not seen because of cataracts. The neck was supple and presented no abnormalities. The chest was clear, the heart normal. There was no organomegaly. Pulses were diminished in the feet, but were normal elsewhere.

Hemoglobin was 10.5 gm%; hematocrit 30%. White blood cell count was 5,400 with 7% bands and 57% adult polys, 27% lymphocytes and 10% monocytes. The urine was clear, acid, with a specific gravity of 1.027, no sugar or protein and free of formed elements. Blood sugar was 120 mgm%; blood urea nitrogen 15 mgm%. Sodium was 128; potassium 2.4; chloride 99; and bicarbonate 15 mEq/l. Serum salicylate level was 120 mgm% and barbiturate level 10.38 mgm%. A portable chest film demonstrated some cardiomegaly and basilar atelectasis of the right lung. The electrocardiogram was unremarkable.

Large volumes of fluid with potassium chloride and sodium bicarbonate were administered and 50 mgm ethacrynic acid was given intravenously to maintain a urinary output of approximately 400 cc/hr.

By the next morning, the patient had not improved and her respiratory efforts lessened. An endotracheal tube was placed, resulting in severe bronchospasm which rapidly led to hypoventilation and cardiac arrest. Resuscitation was performed immediately. Controlled ventilation with an Emerson unit measuring 60 cm water pressure was necessary to overcome the bronchospasm despite the continuous infusion of isoproterenol and periodic administrations of epinephrine. Subsequently, subcutaneous emphysema of the right chest developed. A chest film demonstrated the subcutaneous emphysema and suggested a pneumothorax. No vomiting was noted, but a Levine tube was placed and intermittent gastric suction performed. A pressure of 40-50 cm water was required of the Emerson unit to maintain a tidal volume of 700 cc. At a respiratory rate 12/min and oxygen administered at 4 1/min. the arterial blood gases were: Po_2 125 mm Hg, Pco_2 34.4 mm Hg and pH 7.41. Blood barbiturate level had risen to 15.75 mgm%. An alkaline diuresis reaching 1,200-1,400 cc/hr was accomplished with large volumes of fluid, bicarbonate and mannitol. Large amounts of potassium and calcium were required to restore these serum values to normal levels. Because of abdominal distension, additional x-rays were taken and

demonstrated a gross pneumoperitoneum and significant elevation of the diaphragms. Later in the day the blood barbiturate level was reduced to 11.1 mgm%.

On the second hospital day, the patient remained unchanged; 2800 cc of air was aspirated from the peritoneal cavity and resulted in a lowering of the diaphragms and some reduction in the bronchospasm. Afterwards, blood gases demonstrated Po_2 52 mm Hg, Pco_2 44 mm Hg and pH 7.59 with the Emerson unit measuring a pressure of 40 cm H_20, a tidal volume of 700 cc, a rate of 12/min and oxygen administered at 11 l/min. Chest findings were unchanged. Chest x-ray suggested bilateral perihilar densities.

By the morning of the third hospital day, the patient had not improved. Chest examination was difficult because of the subcutaneous emphysema, but the breath sounds were coarse and distinctly bronchial throughout. Neither wheezes nor forced expiration were noticed. A chest film demonstrated bilateral, hilar infiltration. Central venous pressure was 10 cm H_20. No gallop was present. The total WBC count was unchanged, but the differential demonstrated 2% myelocytes, 20% meta myelocytes and 50% bands. The patient remained afebrile. The arterial oxygen tension was 49 mm Hg despite administration of 100% 0_2 through the Emerson unit at a pressure of 40 cm water. The other blood gases were unchanged. Pulse was 120/min. Blood pressure was maintained with vasopressors. A tracheostomy was performed and Keflin and hydrocortisone administered. Ventilation was maintained with the Emerson unit and 100% 0_2.

The patient continued to deteriorate, developing progressively more severe cyanosis with an oxygen tension of 37 mm Hg and Pco_2 of 74 mm Hg despite the administration of 100% oxygen through continuous controlled ventilation. The chest films demonstrated increasing pulmonary opacification bilaterally. The blood pressure dropped to unobtainable levels and the patient died.

FIGURE 1

ORIGINAL film on admission shows some pleural effusion and atelectasis.

DR. HUNTER A. SOPER: Our discussion today centers around a lady who had pulmonary problems. The x-rays are of importance and we'll ask Dr. Miller to start off with the demonstration of the x-rays.

DR. ROSCOE MILLER: Figure 1 is the original film on admission; a portable film showing what appears to be some pleural effusion bilaterally and some atelectasis in the lower lung fields. There is no evidence on this film of pneumothorax or pneumoperitoneum.

The next film (Figure 2) shows massive subcutaneous emphysema, as well as an endotracheal tube in the trachea. There is what appears to be density above the right diaphragm, curvilinear in fashion, which was interpreted by one radiologist as a pneumothorax with a subpulmonic accumulation of air; but on closer examination, one sees that this is a gross pneumoperitoneum with a large amount of air in the abdominal cavity. One sees the air in the abdominal cavity on the left diaphragm, raising the diaphragm bilaterally.

Figure 3 is the last one. There is again gross dissection in the pectoral muscles. The pneumoperitoneum has been decreased, but the subcutaneous emphysema still remains rather extensive.

DR. SOPER: To discuss our case we have Dr. Roy Behnke from the Veterans Administration Hospital.

FIGURE 2

THIS film shows massive subcutaneous emphysema.

DR. BEHNKE: I'd like to propose that the approach to this patient, so that we all may learn something from this particular problem, be divided into two phases: One phase, the period of time in which she ingested the barbiturates up to the point at which she required intubation, and the second, that period after the intubation.

FIGURE 3
THE pneumoperitoneum has been decreased, but the subcutaneous emphysema remains rather extensive.

As you know, this woman had a number of factors going against her. First of all, she was 67 years of age. Secondly, she was obese, and thirdly, she certainly had ample evidence of pre-existing disease, having been virtually confined to bed for four or five years, having had a past history of well-defined thrombophlebitis. One might wonder, then, with this kind of history, whether she might not at some time in her lifetime have had pulmonary emboli. So we have a situation in which the person at the time she made the decision to attempt suicide had a number of problems which made subsequent management of her problem much more difficult and her chances of survival much less certain.

Originally barbituric acid, which is a condensation of malonic acid and urea, was effected in 1864 by a young chemist 29 years of age, by the name of Bayer in Ghent, Holland. He was very exuberant about having discovered a new compound and betook himself to celebrate. The idea as to how barbiturates acquired their name originates in this celebration. Apparently that particular day was St. Barber's Day, the patron saint of the infantry officers, and in a round of drinking, Bayer and the infantry officers decided that the synthesis of Barber and urea was a combination which lends then to barbituric acid and the term itself. The second idea that Goodman and Gilman quote, however, was that Bayer was enamored of a young lady by the name of Barbara and decided to honor her by his discovery. However, the compound, barbituric acid, certainly isn't a sedative or hypnotic, and it remained until 1903 for the first compound, Veronal, to be introduced on the market as a hypnotic. In 1913 phenobarbital, the second of the barbiturates to be used clinically, was introduced upon the market under the trade name Luminal. Now barbiturates are manufactured in this country at an awe-inspiring rate. The latest data that I could find indicate that there are around 900,000 pounds of barbiturates produced in the United States every year. That's about 6,000,000,000 60-mgm capsules, if you want another way of looking at it. That provides enough for each of us in the country to have 33 60-mgm capsules per year, so if you are not taking your share, you can understand that there is a reasonable amount left over for the doubling of consumption for individuals who are habituated and addicted to them.

Phenobarbital is a very long-acting compound. Only about 30% of it is excreted by the kidneys and the rest of it is metabolized. It requires a considerable period of time for the onset of the full toxic effects, or even the therapeutic effects, of any given dose. We knew that the phenobarbital was taken in combination with codeine, which also effectively depressed her respiration. The codeine was in combination with some salicylates, as we learned from the laboratory data later on in the chart, which indicated she also had a reasonably significant salicylate level.

When she was admitted, she was described as comatose, as essentially areflexic, retaining only the corneal reflexes, and as having an adequate respiration of approximately 12 cycles per minute. I am certain that all of you, as you approach barbiturate intoxication, may have some classification, because I think it is necessary to classify the illness in order to decide upon the therapeutic regimen.

First of all, if one uses four stages, stage I is simply a patient who is intoxicated, comatose, but who would withdraw from painful stimuli. Certainly she didn't fall in this particular category. The second stage might be one who is comatose, who would not withdraw from painful stimuli; in the third stage, comatose, almost absent reflexes and no response to pain, but no depression of respiration and no depression of circulation. I think this was her status upon admission to the hospital; stage III of barbiturate intoxication. She was in stage III principally because there was a rather short time between the ingestion of the drug and her admission to the hospital, and that as she was observed in the hospital, the further effects of the barbiturate became observed and she then slipped into IV, which is comatose, reflexes totally absent, circulatory and res-

piratory depression. I think we should consider how we would treat her and compare our feelings with the manner in which she was treated.

First of all, she was lavaged. Now there is no universal agreement among people who treat barbiturate intoxication as to whether lavage is good or not. Generally, it is said that if you see the patient within four hours of ingestion, lavage has some advantage; after four hours you run into the problem that a certain number of people, when lavaged, aspirate and then have subsequent pulmonary difficulty. The second principle of management is the maintenance of respiration and airway and this is certainly only a consideration in a comatose patient, much more a consideration in a stage III or IV patient.

When admitted to the hospital, she was observed for a period of time. It's not known whether she was given oxygen during this particular period or not, and we don't have any blood determinations to determine exactly what was going on, but at the moment it would seem to me the consideration at this particular point might well be: did we look at her ventilation in the terms of whether it was adequate or not? Is a visual inspection of respiration in a stage III or IV barbiturate intoxication sufficient? Be that as it may, it does seem that some kind of management with blood gas determination should constitute basic management for these patients.

A stage II patient is an anesthetized patient and should be managed accordingly. Also the problem of maintaining and handling secretions, either through an endotracheal tube or tracheostomy tube, can rather quickly be summarized by saying that if you expect the patient to have assisted respiration for a long period of time, the endotracheal tube should not be used; you should initially start with a tracheostomy. If you feel it's a short-acting barbiturate and you'll be out of trouble in a short period of time, an endotracheal tube might well handle it.

The fourth factor is prophylaxis against infection. There is an argument as to whether prophylactic antibiotics work or not. The maintenance of a high urinary output and alkalinization is thought to be rather effective in mobilizing what barbiturates have redistributed themselves about the body. In this particular situation, I think what happened is that during the period of time in which she was observed and diuresis was being effected, she became rather severely acidotic. At this time it became necessary to intubate her, and she was in the very situation in which intubation is most apt to create both laryngospasm and bronchospasm. This was then rather rapidly complicated by cardiac arrest, again a feature which certainly might be possible since she had become not only hypoxemic but acidotic.

Apparently she was re-started with acute emergency mechanical cardiac massage. I think the question arises, as it is stated in the protocol, whether this was really bronchospasm or not. The Emerson machine which was used is said to maintain tidal volumes somewhere in the range of 700 to 800 cc. She had to be pushed initially with 60 cm of water positive pressure in order to effect 700 cc of exchange. Later on, they were able to reduce this to somewhere between 40 and 50 cc of positive pressure in order to move 700 cc 12 times a minute. I think there was tremendous resistance in this chest. I think this resistance can come about in a number of ways. It is entirely possible that during the period of her coma she had secretions which accumulated in her tracheobronchial tree, and in the process of emergency resuscitation or even in the process of natural course of retained secretions, many of the terminal bronchioles became effectively plugged. Essentially what you were doing then with the Bennett was attempting to push against a lung which can't really take air because the terminal, multiple, small bronchioles are occluded by inspissated mucus. She also developed large areas of atelectasis, perhaps not large enough to be detected as gross lobules, or lobes, on the x-ray.

Secondly, I think it was compounded by the problem of the air getting about in her chest. Now I wish I were as sure as Dr. Miller that this did get there the way Macklin and Macklin described it, namely, when you push gas in the tracheobronchial tree and push with enough positive pressure, blebs can rupture and the air can dissect retrogradely along the perivascular space into the mediastinum and thereby gain access to the neck and the subcutaneous tissues. I think this is certainly one possible mechanism in this particular instance.

I wonder whether it might be possible that we have missed a small pneumothorax which had been effected by the cardiac massage. She was an older individual with rather brittle ribs. The mechanical massage could have perforated her lung, both the visceral and parietal pleura. Then we have a communication between the lung and the subcutaneous tissues, and I think most of us have seen pneumothoraces which have suddenly decreased in size because they have gained access either through visceral or the parietal pleura to the mediastinal structures. I think the question arises: How does the air get into the abdomen?

Those of you who have looked and had some experience with pneumoperitoneum can read of the instance in which a very effective pneumoperitoneum is introduced; the individual has gone home and you are called two or three hours later, "Doctor, I can't swallow." "Why can't you swallow?" "Well, my tongue won't work

right, and when I feel under my neck, I've got a lot of crackling, just as though I'd taken a bowl of Wheaties and crinkled them up—that's the sensation under my jaw." And you will find, if you bring him back in, that indeed the very nice pneumoperitoneum dissected up along the esophagus through the mediastinum on up into the neck and subcutaneous tissues beneath the tongue. The mediastinum and peritoneum are in communication and particularly when you generate positive pressures. It also is entirely possible that a fractured rib might have caught the diaphragm on the left side and air from the chest entered directly into the peritoneal cavity.

We know, of course, that patients with cirrhosis get fluid in their chests, thought to be transported there through small, minute defects in the diaphragm, 1 or 2 mm or less in size. I think it is entirely possible that if you generate the right kind of gradients between the chest and the abdomen that you can then push air back and forth between pleural and abdominal cavities. I am sure that those taking care of her initially felt as I would have — that the abdominal distention was simply due to the fact that people on Bennett or positive-pressure machines of any sort have air pushed into their stomachs as well as their lungs. I think probably the initial attempt with a tube was to determine whether there was indeed a distended stomach. This is the usual reason for abdominal distention when you are using such machinery. I think the air can get around, first of all, by dissection along a vessel. I think it can come through rupture of the visceral and parietal pleura and dissection in the subcutaneous tissue, this effected by a fracture of the rib.

I think there is a third consideration, not a very pleasant one to consider but one which we must face, namely, when one is forced to manipulate tubes under emergency situations; you and I do not have the time to handle tubes as we would ordinarily handle them. I think it is entirely possible to manipulate this endotracheal tube too abruptly and perforate the trachea. The trachea in an older person, as you know, does not have the elasticity that it does when you are younger. It is also entirely possible that the endotracheal tube might have been displaced downward into either the right or left mainstem bronchus and the original efforts at ventilation shoved everything, from this positive pressure, into one lung or the other. These are considerations which I think must always arise when you and I are forced to place tubes under very disadvantageous circumstances and this certainly must have been such a situation.

We find in the second phase of this particular hospitalization our problems become not those of barbiturate intoxication but essentially those of accomplishing ventilation. She began after intubation with a very normal PO_2. As time went on, her problem was compounded by the fact that she got sicker and sicker, accompanied by increasing difficulty with ventilation as evidenced by the falling PO_2. I would propose that the ventilated segments of her lungs and the perfused segments of the lungs really bore only a very crude relationship, one with the other. Ordinarily we ventilate and perfuse segments relatively equally. This woman had a preexisting situation which might well have compromised her circulation very early in the course of her present illness or even years before.

She picked off various segments of her lung circulation with multiple pulmonary emboli, having created before she took the phenobarbital the potential for a disturbed ventilation-perfusion ratio. She then had the experience of the barbiturate intoxication, a period of hypoventilation, poor relief of retained secretions, so then in the acute situation, began to pick off the ventilation in her lungs. I think that slowly, over these few days, starting out with distorted ventilation-perfusion ratios, these got worse and that as the case progressed, her oxygen fell from the high levels of our initial ventilation down to a low level and that her CO_2 rose, even though it was originally quite normal and well maintained on mechanical ventilation, as her lung became less functional.

I think Dr. Miller's x-rays show the progression of atelectasis and/or some fluid in this chest. I think that what happened is that we eventually completely dissociated, if you will, the ventilation and perfusion and were unable to maintain either oxygenation of arterial blood or the maintenance of adequate excretory function of CO_2. I believe she became acidotic, the acidotic state then contributed, as it often does, to cardiovascular collapse, sudden peripheral vasodilatation and shock. I think her basic difficulty was with retained secretions, and that these retained secretions became inspissated and impacted well out in the periphery of the lung in small bronchi and bronchioles, that this effectively altered her ventilation, making air exchange difficult. Secondly she had pre-existing disease and eventually a cardiovascular collapse further compromised this all-important relationship between ventilation and perfusion, which is necessary to maintain oxygenated arterial blood and to maintain adequate acid-base balance by the ability to get rid of CO_2. This was all obviously started and effected by the fact that she anesthetized herself with a long-acting barbiturate.

I should mention the recent experience that people have had with dialysis, particularly with the long-acting barbiturates. There are increasing numbers of reports concerning the problem of managing the patient who takes long-acting barbitu-

rates and the fact that most of these are quite dialyzable. One of the modalities of treatment being presently proposed, particularly for the long-acting barbiturates, is that hemodialysis offers some hope of at least rapidly reversing the high blood levels.

In conclusion, I would like to say that so far as I am concerned, her death was due to atelectasis and numerous small segmental areas of atelectasis initially, perhaps even, as the prosector will tell us, large massive areas of atelectasis at the time of her demise. I believe that the lung function may have been compromised by pleural effusion, but I don't believe that the pleural effusion was in any instance a major problem. She had circulatory difficulties on a pre-existing basis, namely her long-standing thrombophlebitis with the well-known possibility and even probability that she threw multiple pulmonary emboli during her lifetime. We then had the period of hypoxemia and acidosis which further effected deterioration of cardiac function to compound the problem. I think she had the situation complicated by a tear of the lung parenchyma, and I would suggest that the tear was probably both in the visceral and the parietal pleura. Therefore, when we were forced to use high degrees of positive pressure to ventilate her, we effectively pushed air in and about the mediastinum and subcutaneous tissues and indeed even down into the abdomen. I also think the prosector will obviously have to find and show us some inflammatory process, for it seems to me highly improbable that this woman with her altered immunologic status, evidenced by the fact that she didn't respond at all with elevated white blood count for fever, did not have some element of infection. It seems to me impossible to have atelectasis, retained secretions, and not in a period of four days have an inflammatory process.

DR. SOPER: Thank you Dr. Behnke. As usual it was a very fine discussion. The pathologist is Dr. Petty. He will proceed now with discussion of the autopsy findings.

DR. CHARLES PETTY: It's always interesting to find that different people emphasize different points of a given case. I find myself emphasizing some different points, I believe, than Dr. Behnke did. I believe your points were atelectasis, retention of secretion, difficulty in pulmonary function based perhaps on pleural effusion, atelectasis, circulation difficulties, the question of pulmonary emboli, tear of lung parenchyma and some sort of inflammatory process. I think that you are quite close to the real picture.

Let me tell you what the autopsy showed. The woman, mind you, weighed 180 lbs. and she was only 5 ft., 5 inches tall. The thorax was interesting in that both pleural cavities contained a significant amount of yellow, slightly cloudy fluid — 500 cc on the right and 600 cc on the left — with the right pleural cavity at least partially obliterated by numerous adhesions. There was dissection of air subcutaneously, into the mediastinum, beneath the diaphragm and into the retroperitoneal area. There was some subcutaneous emphysema as seen clinically; the anterior thoracic wall appeared somewhat puffy. Approximately 50 cc of nearly clear yellow fluid was found in the abdominal cavity and the retroperitoneal emphysema was present down to the level of the pelvic brim.

The lungs were heavy — three times normal weight; they had smooth surfaces except where the adhesions were, of course; they were firm and nodular, and on cut section large quantities of serosanguineous fluid poured forth.

The heart was interesting in that it was considerably enlarged; it weighed 560 gm., about twice normal size. Even considering the woman's length and weight, you can't push the normal heart weight much above 350 gm., and hers was 560 gm., with rather marked increase in thickness of both the interventricular septum and left ventricular wall. There was some moderate degree of arteriosclerosis involving the coronary system. The coronary system was of a balanced type. I would say that the coronary lumina were narrowed to less than 40% of normal in many areas by means of the arteriosclerotic plaques. I would also point out that there were some gray-white areas of scar tissue in the myocardium.

I would like to make a few comments about the blood barbiturate level. If you look at your protocol, you will find that the first level was in the neighborhood of 10 mgm%, a second level the next day was up as high as 15 — almost 16 — mgm%. Later it went down to 11 mgm%, and I believe one of the reasons for this is the presence of a large number of undissolved, or partially dissolved, white tablets still in the stomach. There were about 20 or 25 of these. I would suggest that the gastric lavage was not very complete. A second reason for some problems in the barbiturate level is the presence of liver and kidney disease, as I will point out in the microscopic slides. The liver was cirrhotic. The kidneys had a 2+, moderate to marked degree of arteriolar nephrosclerosis present. There were fractures of left ribs numbers 3, 4, 5, and 6 in the anterior to mid-axillary line. Dr. Miller, were these fractures present on the x-rays?

DR. MILLER: I did not see them on the chest film. They were portable chest films of poor quality and I did not see them. Did you find tears in the visceral and parietal pleura?

DR. PETTY: There were none. I didn't see any and the fluid which

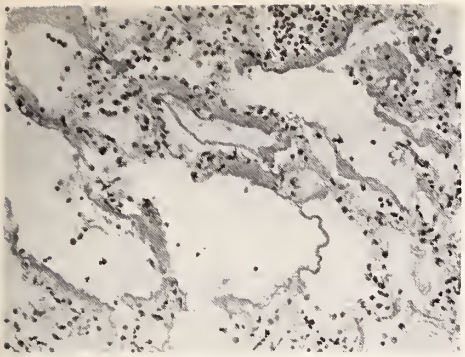


FIGURE 4
PHOTOMICROGRAPH of lung. Note particularly the hyaline membranes closely applied to the alveolar surfaces. Also note the acute inflammatory cells in some of the alveolar spaces (H. and E. 170X.)

was present in the left pleural cavity was not discolored; it was yellow. There was no blood there and I don't believe that there were any tears.

The problem of phenobarbital intoxication is a fascinating one which I will try to interdigitate with my discussion of the pathologic slides.

Figure 4 is of the lung, showing one thing that Dr. Behnke mentions, the presence of a rather large number of hyaline membranes which you will see at the periphery of the alveoli and appearing as rather red-staining areas inside the alveoli and appearing rather prominently. Within the alveoli themselves, of course, there is a mixture of inflammatory cells, primarily polymorphonuclear leukocytes, also some rather eosinophilic material — proteinaceous, I would assume, from its staining and also in some areas some fibrin; so I think that there is something blocking the passage of air or gases into the blood stream.

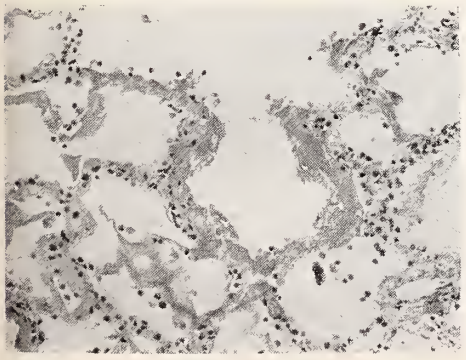


FIGURE 5
ANOTHER view of the hyaline membranes within the alveoli (H. and E. 170X.)

Figure 5 is a higher power view showing the mixture of inflammatory cells present within the lung itself. This is true in all sections examined. The woman had a massive bronchopneumonia with these hyaline membranes which I have come to associate with long-term efforts at respiration by an assisted respirator system. I think this gives rise to difficulty in the passage of gases into and out of the blood stream.

The heart showed hypertrophied, large myocardial fibers, areas of scarring and decrease in size of fibers, atrophy of fibers, dropping out of fibers and areas of thickening of one of the very small ramifications of one of the coronary arteries. This is of course indicative of hypertensive heart disease and also arteriosclerotic heart disease.

The kidney showed some degree of scarring. There were areas of scarring underneath the capsule. Some of the glomeruli were obviously dropped out as a result of massive scarring. There was a rather marked degree of arteriolar disease, that is, thickening of the intima, subintima of the very small arteries in the kidneys.

The liver was obviously cirrhotic. Now a cirrhotic liver is not normal in function and I would assume that the presence of this cirrhosis hindered liver function and caused the liver to poorly detoxify barbiturates. This and the kidney disease may well be reasons that the blood barbiturate did not drop off rapidly.

Now, in dealing with phenobarbital intoxication, if the individual is not a chronic ingester of phenobarbital, one can expect coma to develop with a blood level of approximately 5 mgm% — some people only 4, some people 6 perhaps, but around 5 is a good rule of thumb. This woman started out with a blood barbiturate (phenobarbital) level of approximately 10; now, a second good rule of thumb, clinically, is to take this level at which the ordinary individual becomes comatose with phenobarbital and subtract that from the blood level that you have — in this instance it would be 5 taken from the blood level of 10, leaving 5 divided by 2 and have about a 2½ day period of unconsciousness if you don't treat the individual by means of hemodialysis and if no complications exist, such as cirrhosis, kidney disease or continuing absorption of material from the G-I tract. This is a good rule of thumb and a nice one to follow. It will hold true only if there are no developing complications, such as pneumonia, etc.

The mechanism of pneumoperitoneum production as being that of Macklin and Macklin is well known; it's difficult to demonstrate; it does involve the rupturing of a bleb on the surface of the lung and then retrogressive dissection of air under the pleural areas and the subpleural areas and along the courses of the blood vessels. Now this can be demonstrated histologically by taking sections from the lung. It was not demonstrated in the case at hand. It is not demonstrated because I'm not entirely sure as to the technic of processing of the lung sections here. Figures 6 and 7 (not from the case under discussion) show some rather large perivascular and peribronchial areas of dissection of air in a case which *is* of the Macklin and Macklin type production. Now this lung was very similar to the one that was seen in our woman today and the mechanism for the production of this air dissection may very well have been the same one that was employed here. The most common cause, in my experience, is the over-sized endotracheal tube thrust into the obese individual, and put down too far. The reason for this is very simple: the obese person, such as this woman — 5 ft. 5 and 180 lbs. — looks large. If you remove the skin and subcutaneous tissue, you will find

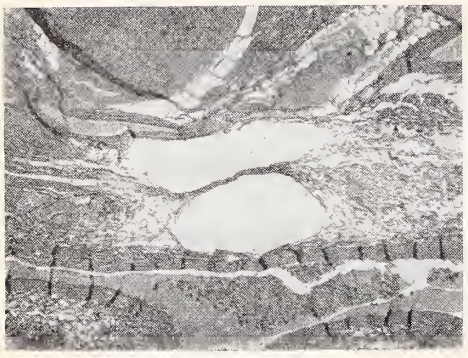


FIGURE 6

PHOTOMICROGRAPH of a lung where air dissection of the type of Macklin and Macklin was found. Note the large air spaces surrounding one of the bronchi and in apposition to a blood vessel (H. and E. 110X.)

that the soma is really quite small. It's the tendency of everyone to overestimate the size of the woman and to use too large a tube and to jam it down too far. This causes difficulty with the respirator or an anesthesia machine with hand-assisted bag respiration. A blow-out in the lungs, or a ball-valve phenomenon, and the dissection of air into the retroperitoneal, retropleural, mediastinal areas results. I believe that is probably what happened here, although I'm reluctant to state it positively.

I would sum this up by saying that this woman died eventually of an underlying cause of phenobarbital intoxication, that she continued to absorb phenobarbital from an incompletely washed-out stomach, that she did not destroy the phenobarbital as rapidly as she should because of cirrhosis and kidney disease. Because of cardiovascular disease and interference with respiratory function, she had respiratory disease problems based on emphysema which was artificially produced. In my opinion, probably by placing a too large tube down a small trachea and larynx, she also had the problem of effusion bilaterally, that she had hypertensive and arteriosclerotic cardiovascular disease not really suspected because her blood pressure was low due to the coma and shock-like state she was in, that she had hypertrophy of the myocardium and scarring of it and the usual changes in the kidneys of arteriolar nephrosclerosis. Her respiratory exchange was all "gummed up", to put it in the common vernacular, by emphysema, effusion, pneumonia, drug depression, hyaline membranes and all the other phenomena that were already mentioned. I should also comment that I personally feel that if I take phenobarbital without a real deliberate intent to commit suicide, I'd like to have somebody wash my stomach out completely and thoroughly.

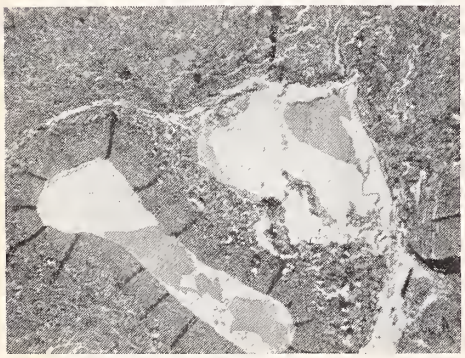


FIGURE 7

PHOTOMICROGRAPH of a second section from the same case as shown in Figure 6 (H. and E. 110X.)

DR. SOPER: I think we have time for a few questions, and I'm sure there will be some. I think we will start with questions from our audience here.

DR. JOHN HICKAM: From my point of view, the striking clinical finding in this lady is that it was so hard to push air into her, and I tend to believe that that really was the basic reason for the emphysema. I would like to ask Dr. Petty whether he actually found any evidence that the tube which was put in did actually dissect the trachea or rupture it.

DR. PETTY: There are some little cracks in the lung tissue, that is, on microscopic review, but I'm not entirely clear of the technics involved, and I don't know how much of it is artifactitious; it may very well be that this is the mechanism. I think it is, but I'm reluctant to say so 100%.

DR. HICKAM: I'd like to make one comment, then ask one more question. Dr. Behnke pointed this out. When you have to use a pressure of as much as 60 cm of water to ventilate somebody, you are apt to produce the picture of circulatory collapse because you are interfering that much with return of venous blood to the heart. The most remarkable thing in this lady was the enormous amount of pressure required to distend her lungs. Dr. Behnke pointed out this could be because she had enough inspissated secretions through the lungs so that most of it was not distending and that is a good way to make ruptures in the lungs. I'm not quite sure, Dr. Petty, just what you think made those lungs so hard to expand during the course of this disease. Was it blockage of the minute airways? Was it the hyaline membrane changes? What was it?

DR. PETTY: Well, the woman had something like 500 cc less pleural area in which to expand the lungs because of the fluid present.

DR. HICKAM: I couldn't count that as very much though, because you can breathe easily with 500 cc of fluid in the pleural space.

DR. PETTY: Secondly, she had a lot of hyaline membranes present. Thirdly, she had — I wouldn't say they were solid lungs, but they certainly were well advanced pneumonic lungs with all of the fluid which you would expect there plus the vital cell reaction, and of course the hyaline membranes which I think really do contribute to a poor air exchange. I think all of these together add up to poor expansion of lungs.

DR. HICKAM: Did you actually see any inspissated bronchioles or plugged bronchi?

DR. PETTY: No.

DR. SOPER: These hard nodular areas — these were just of pneumonia, would you say?

DR. PETTY: Yes, with variations in degree.

DR. GEORGE LUKEMEYER: In retrospect it looks as if hemodialysis would have been ideal, but I would want to emphasize several things. In phenobarbital intoxication, by and large, excretion is almost exclusively by the kidneys, so you don't worry too much about the impact on the liver, the way you do with the short-acting drugs. But more importantly and the thing that concerns me, is pushing the idea that you "wash out" the stomach. This is very rare to have pills stay in the stomach this length of time, but by and large, and this is especially true in the short-acting barbiturate intoxication where you don't see the patient promptly, if more than an hour has gone by, there is much greater harm in trying to "wash out" the stomach because of the possibility of inducing some aspiration type of pneumonitis than there is in ignoring them. So, if you have phenobarbital overdosage and you are detected within a matter of an hour or so, then I think this becomes a legitimate form of therapy, but otherwise I think it's more harmful, and it has been demonstrated a number of times.

DR. SOPER: I think we might say just a word or two about dialysis here. We have, of course, to consider the use of ethacrynic acid diuresis as was done here as an effective thing to do. Hemodialysis, if it has a place, can be useful for phenobarbital overdosage. Do you have, Dr. Kleit, any guidelines as to blood levels or any other way to indicate when hemodialysis should be considered in intoxications?

DR. STUART KLEIT: I think the problem is with the use of alkalinization, and in induced diuresis the guidelines are changing rapidly; however, I think it's generally agreed at this point that the patient in class 4 should be hemodialyzed. The numbers given previous to the induced diuretic method were 3 mgm% for short-acting barbiturates and 8 mgm% for long-acting barbiturates. I think I would be more inclined to follow the clinical course, and that if the patient became a grade 3+ or a grade 4, he should be hemodialized. I would agree with Dr. Lukemeyer that doing this gastric aspiration can be a very big problem with these patients; however, it is frequent that the patient will have a two-phased disease; that is, he is dialyzed from a class 4 to a class 2, and then several hours later when the patient is awake, he will go back to sleep. Usually this is associated with shock occurring during the class 4 period. They stop absorbing whatever barbiturate is left in the gut, and then as you get them better, they begin to absorb it again. This can be prevented in the patient who has an extremely high level by doing first hemodialysis, and as soon as that is completed, starting peritoneal dialysis. The patient then leaves the dialysis having been dialyzed both ways and continues the peritoneal dialysis afterwards. The use of induced diuresis is fine up to class 4, but I think once you get to class 4, you have to dialyze the patient. You will decrease the mortality and the morbidity which is largely pulmonary, and if you can do this, especially in the older patient, you can save more patients.

A PHYSICIAN: Is there any way from the blood gas values to differentiate between the abnormality of ventilation perfusion or an abnormality of diffusion? Secondly are we going to be seeing more hyaline membrane in the alveoli of those lungs with the use of intermittent positive pressure breathing?

DR. BEHNKE: Usually patients who experience diffusion difficulties have a great deal more difficulty maintaining oxygenation than they do in maintaining normal acid-base balance. It is much easier for the lung to compensate and even for a damaged mechanism to transport CO_2 than it is to transport oxygen, so that very often your blood gas analysis data will show the patient who has a diffusion difficulty will have hypoxemia without acidosis, in fact, may actually have a slight degree of alkalosis because of the attempt by increased ventilation to compensate for the hypoxemia. The question of hyaline membrane disease I think is totally unsolved.

I think as we use more and more treatment modalities involving both oxygen and positive pressure, this is going to be a problem to us. Our present state of knowledge indicates that it is not so much the intermittent positive pressure at the usual therapeutic levels with which we treat patients, but rather the fact that we are bathing most of these people with a very high oxygen content. In other words, this is a form of reaction, if you will, to oxygen per se. It usually does not occur in a period as brief and as short as this. Most of the patients who have been demonstrated to have hyaline membrane disease in the adult age group have been patients who have been ventilated for much longer periods of time than this woman. I can't resist the statement that lungs that weighed and looked like this could hardly have much going in and out of at least the bronchi themselves, with the fluid and the mucus, and the inflammatory exudates lying in them.

DR. JOSEPH ROSS: In response to that first question that Dr. Behnke has answered, I might add that if this were strictly a diffusion problem and no ventilation perfusion abnormality, the addition of high oxygen

would have brought the oxygen saturation to 100% and to PO_2 very high; so the fact that with high oxygen the PO_2 was still low indicates that this was not a diffusion problem. It could have played a part in it, but it certainly was not the main part. I saw this patient the morning after most of this had happened, and certainly she should have been intubated when she was admitted to the hospital. Blood gases should have been obtained and should have been followed throughout the night, and I pointed this out to the house staff the following morning.

DR. PETTY: I must add that we see extensive hyaline membrane formation within 12 to 24 hours at the autopsy table on individuals who are dead from a variety of reasons and who have received artificial ventilation for a variety of reasons — usually head trauma.

DR. BEHNKE: I have examined lungs for many years, both clinically and at autopsy, and I wonder why it is that we are now so suddenly aware of it if it is formed within 12 to 24 hours. Up until the last three or four years, in fact until it was recorded as far back as 1958 at Ohio State, we didn't even find it at all.

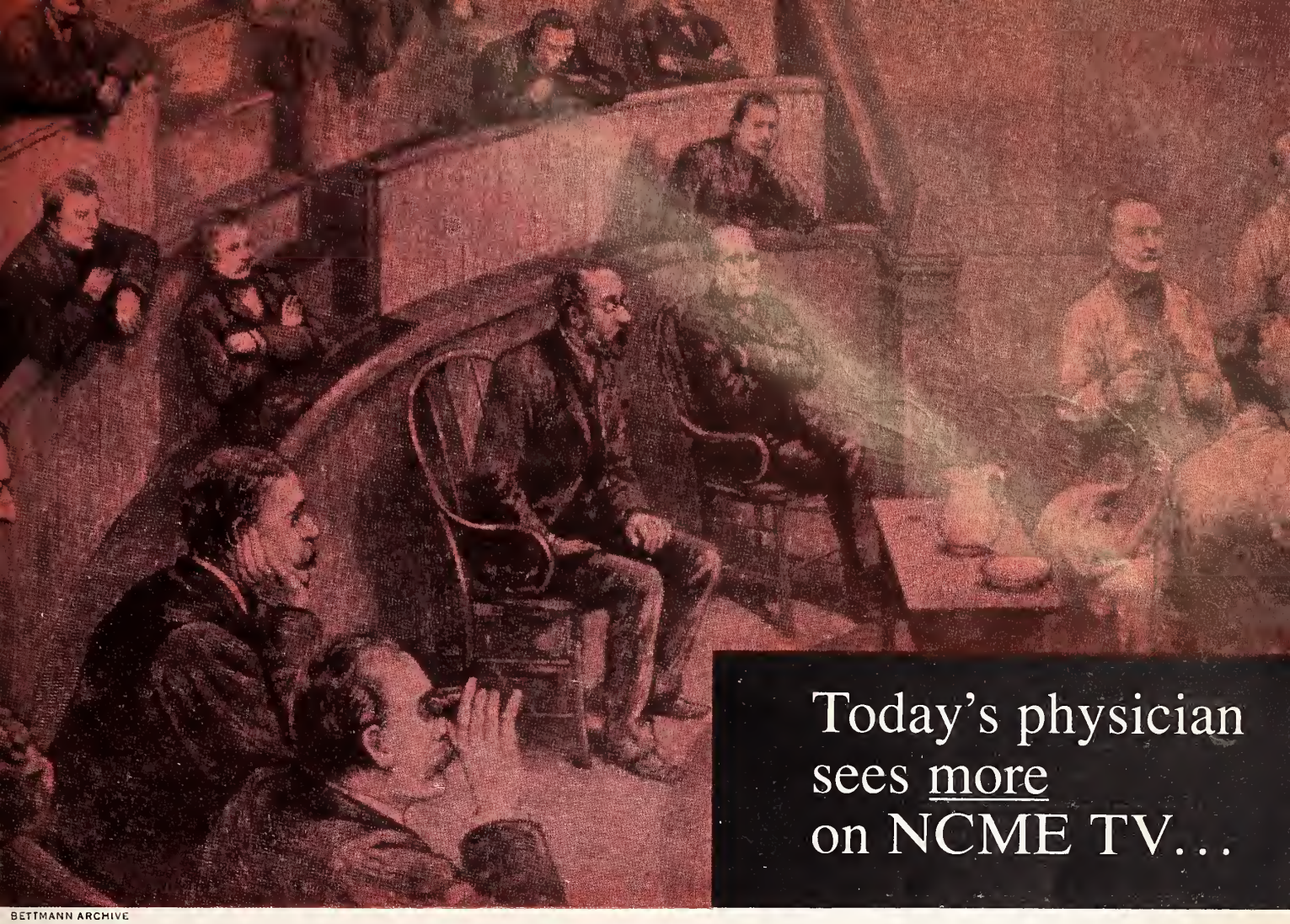
A PHYSICIAN: Would the use of succinylcholine have helped in determining whether you had bronchospasm by decreasing the pressure with the use of Emerson?

DR. BEHNKE: I really don't think that it would. This was a stiff lung — parenchymally it was intrinsically stiff from a variety of reasons.

DR. WALTER DALY: I have two comments with respect to the increasing difficulty ventilating this patient. In the few patients I am aware of who have been described with this syndrome of interstitial emphysema of the lung, increasing difficulty with mechanical ventilation has been a part of their problem. Dr. Baker very recently produced this in some isolated lobes of dogs and when they are over-inflated, they very rapidly become totally impossible to ventilate. The other problem I would like to refer to is the problem of oxygen toxicity to which we have all been alluding. I think that it is quite possible that this was the factor which caused this patient's deterioration terminally. Now, with respect to the hyaline membranes and their time of appearance, I happen to have on my desk right now 25 charts which the pathologists gave me, of patients with hyaline membranes. They go back over quite a long period of time. It is very difficult to pick out of these any particular unifying thing. All the patients had received oxygen. One of the very common things which these patients had was some kind of a bad hypotensive episode — some kind of tissue ischemia involved — in addition to the oxygen which they got terminally.

DR. PETTY: If you go back into the older literature, you will find all sorts of hyaline membranes described. They have occurred for years and were probably best described back in the 1918-19 flu epidemic. The reason that they are not often seen at the autopsy room today is the fact that most of these cases are sucked off into the medical-legal investigative area. They usually involve head injuries and the like, where people die fairly rapidly. Most of the cases that come to the autopsy table are autopsied not in the institution where death occurs but by the coroner or whoever is the medical-legal representative. That's very probably why you haven't seen a great number of them. They are very common really, and they do come up within 24 hours.

DR. SOPER: I think that the crux of this thing — the thing we need to point out — is that as a physician, whenever a patient comes in with a problem which threatens his respiration and adequate oxygen exchange, this becomes of prime importance, whether it's fractured ribs that develop after attempts at resuscitation with the development of a tension pneumothorax, whether it's a problem of infection, of heart failure; whatever it may be, your prime responsibility is to try to maintain an adequate airway and adequate oxygenation for your patient. ◄



Today's physician sees more on NCME TV...

BETTMANN ARCHIVE

The first nationwide medical television service, NCME—The Network for Continuing Medical Education—brings you visually the important achievements of leading medical authorities. By means of closed-circuit television, this independent network provides your hospital or medical school with a complete videotape service that helps shorten the gap between new medical knowledge and its availability for clinical or teaching purposes.

NCME The Network for Continuing Medical Education

NCME TV Offers These Practical Benefits:

☐ Every two weeks a new 60-minute videotape dealing with three separate medical subjects is sent to participating institutions.

☐ Content and format of NCME telecasts fulfill criteria for postgraduate medical education, permitting American Academy of General Practice course credits under specified conditions.

☐ To help your institution make effective use of closed-circuit television, NCME offers a wide range of services and utilization aids, including: Technical consultation in setting up a closed-circuit system; advance program information on the contents of each telecast; display units to help publicize programs; expense-paid seminars to improve utilization of medical television.

☐ NCME programs are brief and may be shown as often as desired; you can view the telecasts at times that are most convenient, without disrupting your normal schedule.

☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to NCME, 342 Madison Avenue New York, N.Y. 10017

The Case of Sanguinous Sanctity

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

ETYMOLOGY means only that the derivation of a word is traced and the accretion of changing meanings is analyzed. More often than not, the results can be startling. Aberrant human oddities are unexpectantly illuminated; their root etiologies suddenly become explicable.

The four letter word *DUTY* is familiar to all of us. The virtue implies an obligation: what one is morally bound to do. We owe a duty to ourselves to do what we believe to be right: we are a unit in our family; we must fulfill the obligations placed upon us by society, organized locally, nationally and worldwide. Temporarily we might resign by becoming vagrant hoboes and hippies, wallowing in dirt and drugs. However, the vast majority of us overcome our youthful rebellions; we perform our duties to the best of our abilities. Our young men compose our armies. Often they risk their lives. Many become heroes by voluntarily performing valorous deeds over and beyond the "usual" call of duty. Congressional Medals of Honor are all too often awarded posthumously to such elite doers of deeds.

However, this virtue, *duty*, has meant different actions to changing generations in succeeding ages. Zeal, especially in its religious stratifications, can have results that we—today—may view askance. The Reformation and Counter-Reformation had some bloody consequences, indeed! Torquemada's auto-de-fe's; John Calvin burning Servetus at the stake; the Salem witch hunt: excess of zeal becomes fanaticism and bigotry! The list is too long.

An additional example: In the Russia of the early Romanovs, "Old Believers" made the sign of the cross from right to left rather than the Orthodox Church approved motion from left to right. But—was this deviation reason enough for the wholesale execution of the "Old Believers?"

Sickening Syntripsis

All this may be relevant to the case of Sharie Shell.* Her medical precis is truly fascinating but far less complex than her social background. Some years back, I had my first brief sight of her in a hospital ward. She and a boyfriend had been riding a motorcycle. A passing automobile had side-swiped them. The overturned bike had been flung suddenly into the path of a car going the other way. Both the riders had been ground under by the speeding wheels. The young man was DOA on arrival at the emergency room. The young girl, barely a teen-ager, was still breathing even though unconscious and in evident shock. There were no wheel marks on her body. Did the young man's corpse act as a partial shield?

The fact of a crushed pelvis was only too horribly obvious. The hastily taken x-rays confirmed what our fingers had felt and our ears had heard: crepitations where there should have been solid bone. "Multiple fractures of the pelvis . . . bilateral ischial and pubic rami fragmentations . . . right wing of sacrum . . . transverse fracture left ilium. . . ."

The Hb was only 9.0 gm.—B.P. 90/40—rapid, thready pulse—completely limp lower extremities—dullness over lower abdomen. . . .

Fluid replacement was started stat.. Blood was cross-matched. . . . She was taken to the operating room for an emergency laparotomy. It was obvious that the bladder had been crushed and that there was progressing massive intra- and extraperitoneal hemorrhage. Most probably, there was also bilateral lumbosacral plexus injury even if this last was not immediately life threatening.

* All resemblance to actual persons, living or dead, is strictly coincidental.

Pertinacious Parent

In the girl's clothing, the nurses had found a card with her name and address. This latter was Canadian—no matter. The operator called for us. The surgeon spoke to the mother explaining the situation. Permission to perform the emergency surgery was granted readily with one vital exception: *No* blood transfusions! The absolute, life-saving need was explained—this made no difference. The mother said that she was a member of Jehovah's Witnesses. Their tenets absolutely forbid this.**

The child had run away from her stern home. This had made her an outcast from her kin. The mother apparently had accepted the accident as God's terrible punishment of the wayward girl. We could do whatever was needful; permission for blood transfusions was beyond the pale, come what may.

Although it was past midnight, surgery was started even as dextran I.V. with electrolyte replacements p.r.n. was already flowing in. A Superior Court judge was contacted at his home. After listening to our chief of the professional staff, he gave telephone permission for the life-saving blood transfusions. The written order would follow. As the patient was a minor (besides being unconscious) the court had the right to appoint guardians. An adult can refuse *any* procedure and the attending physicians cannot do their *duty*—as they see it—without the patient's informed consent.***

In any case, the surgeons went ahead with the laparotomy even while they waited for the court and the mechanics of cross-matching. Indeed, the bladder had been actually torn loose from its anterior attachments. The enormous masses of clotted and free blood were evacuated. The pouch of Douglas was mopped dry; ditto, the intersigmoidal space. The active sites of bleeding were sutured systematically; the bladder was closed tightly and re-anchored in position. A Foley catheter was left in its usual place. The bowels seemed bruised but viable. The operation had been long and difficult. Besides the dextran and electrolytes, no less than *five* pints of blood went into Sharie's veins.

A healthy young body is a marvelous mechanism! Also, the surgeon of today has at his disposal truly exciting instruments and procedures. The patient was beginning to emerge from shock even while still in surgery. She was placed in a body sling; supporting splints held the legs. By the time she was being wheeled into the intensive care unit, Sharie had regained some degree of consciousness!

Those who believe today's medicos to be grubbily absorbed only in the pursuit of fees should have stood by and observed how the entire surgical team labored on this ward case. Obviously, the skilled surgeon who had been on call—and therefore called—did *not* toil through the night for the nonexistent fee. The hospital was well

aware of the fact that it would get only minimal repayment for all that it was supplying, without hesitation, so lavishly!

The ICU had its hands full keeping an around the clock vigil on our patient. Still, Sharie was making history as the days lengthened into weeks and she continued to maintain a steady pace of improvement. The bladder was functioning well; she was having normal bowel movements. Also, by the end of the third week, there were some signs of sensation returning to the paralyzed legs.

Dolorogenic Disruption

On the 22d postoperative day, the patient began to complain to the day nurses ever more strongly of pain in her lower abdomen, more on the left side. It seemed to radiate into her rectum and to her back. A bedside flat plate of the abdomen and pelvis was rather unrevealing although the roentgenologist mentioned an "unusual thickening —growth?—in anterior wall of sigmoid colon."

The gastroenterologist saw her late in the afternoon as the pain became so excruciating that morphine had to ordered. He raised the possibility of a dissecting aneurysm — a consequence of the original crushing of the sacrum? Delayed slough? No one could be certain but the surgeons were alerted for a probable re-exploration.

Shortly after 9 p.m., Sharie began

** *Genesis* IX, 4&5: "But flesh with the life thereof WHICH IS THE *BLOOD* THEREOF shall ye not eat. And surely your *Blood*, the Blood of your lives, will I require; at the hand of every beast will I require; and at the hand of man, even at the hand of every man's brother will I require the life of MAN."
Leviticus XVII, 10: "Whatsoever man . . . eateth any manner of *BLOOD;* I will cut him off from among his people."
Acts XV, 20: "Abstain from . . . things strangled and from *BLOOD*". However, the Seventh Day Adventists differentiate between the forbidden DRINKING of blood and INFUSIONS of blood. They have no objection whatever to receiving or giving blood transfusions.

*** This is not only a legal thicket. What is good treatment in one generation may be totally rejected by the next. Bleeding and purging were the very cornerstones of 18th century medicine. Today we *think* we know such therapy to be positively death dealing! "Ethics in Medical Progress" is an excellent Ciba Symposium on this ever timely topic. (See book review in Aug., 1967, *JISMA*, p. 1113.)

to scream from the lancinating pain —morphine or no morphine. Within another half an hour, even as she was being wheeled to surgery, she was unconscious and in shock. Not only was the eminent original surgeon called; a most prestigious peripheral vascular specialist was also on the scene. Even as the previous incisions were being parted, blood and fluid replacements were finding their way into Sharie's veins. Also, there was need for hypothermia, a cardiac pacemaker and the special O_2 apparatus.*

Between the time of the first prodromal pains and the laparotomy, the Hb had plummeted from 13.0 to a scanty 7.0. Fresh and clotted blood welled from the abdominal cavity as soon as it was opened. The one surgeon put his heavy thumb over the lower abdominal aorta even as the others sucked out the blood and searched for the rent in the major artery. It must have been a most spectacular display of skill, cool courage—and sheer good luck. I'm sorry that I did not get to witness the fireworks!

The left hypogastric artery had ruptured just beyond its origin from the common iliac! The vessel was successfully dissected clear, clamped above and below—and only then brought out of the retroperitoneal depths for a careful look-see.**

Because of the serious fraying of the damaged section of the artery, the surgeons decided to excise and replace with a Silastic prosthesis. Even while the *TENTH* pint of blood was going into Sharie's veins, the delicate job was being completed. Rapid closure was almost an anticlimax. The patient was back on the ward in the early pre-dawn darkness.

Again, the youthful teener amazed the sceptics! She came out of anesthesia smoothly; after rewarming, the respirations were regular. An ordinary O_2 nasal catheter proved sufficient; the cardiac pacemaker was not needed. No expected or unforeseen complications materialized. In fact, a mere week later, she was having real return of limb sensations! In another two weeks, motor function became a fact at a rapidly accelerating pace. The shattered bones were knitting nicely. The body sling and the leg splints were no longer a must.

Two months after the initial terrible accident, Sharie was up on crutches; daily rehabilitation exercises were initiated. No one from the family had bothered to contact her! However, a local woman leader of her sect had come and seen her. Sharie was beyond the pale but still —because of her young years? ?— some arrangements were in the works as to her further care.***

As Sharie ceased being a medical problem, the interest of the attending physicians began to wane. Officially, they were still her guardians; actually, Social Service took over the planning for Sharie's further care. Vaguely, I heard that she had been discharged to the foster care of the woman sect leader already mentioned.

The surgeons reported the case; the local papers carried a couple of brief items anent the medical and social implications of the case. Of course, there could be no furor as that attending a medical first: the first renal transplant or the first successful heart exchange—or some other such spectacular. Sharie Shell faded from our minds.

Dolorific Demirep

And then, just the other day, in the halls of another hospital, I ran into the erstwhile chief surgical resident who had assisted in the case.

"Oh, Dr. L.! I have something to tell you. I trust you have some recall of the long bull session we had anent that girl who had been run over by an automobile and then had to be re-operated for a ruptured

* Clinical applications of hypothermia are on the increase.

Surgical:
- Cardiovascular:
  - open heart procedures
  - aortic aneurysms
  - portacaval shunts
  - carotid artery stenosis
  - acute vascular occlusions
- Neurologic:
  - cerebral aneurysms
  - arteriovenous malformations
  - brain tumors
  - procedures near the hypothalamus
- General:
  - excision of pheochromocytomas
  - toxic goiter
  - organ transplantation
  - procedures with prolonged induced hypotension

Medical:
- General:
  - cardiac arrest (after resuscitation)
  - head trauma
  - septic shock
  - hyperpyrexia
  - hyperthyroidism (postoperative crises)
  - obstetric shock
  - CO poisoning
- Gastrointestinal bleeding (local hypothermia):
  - esophageal varices
  - hemorrhagic gastritis
  - gastric and duodenal ulcers

** When the aorta or a major branch thereof ruptures, the patient is, usually, dead before surgical succor can be made available. Albert Einstein was one notable victim of this condition.

*** Since earliest times (and on all the continents of the world), man had developed the concept that disease was due to *evil* forces invading and taking possession of the patient's body. The Salem witch hunt was merely a logical extension of the idea that *evil* human beings participate in these nefarious activities. A leading Dutch physician, contemporary of Queen Elizabeth I, wrote a treatise on "Witch-Craft and Exorcism." Even today, among all religious groups—Jews, Catholics, Protestants, Buddhists, Primitive Fetishists—there are still splinter sects who have carried these ideas well into the 20th century. For a rather interesting discussion of Satanism, poltergeist, exorcism and allied aberrations I would recommend reading Kurt Seligmann's "History of Magic" published by Pantheon Press back in 1948. Sharie Shell merely had the misfortune of having been born into a group having these beliefs.

aortic aneurysm? All that rhubarb about the court orders permitting the giving of blood to her? Our excursion into the meaning of the word, *duty*, as applied to us as doctors and the implied corollaries of our having become the girl's legally appointed guardians?

"Well! You may not know that I'm now, part time, doing autopsies in the medical examiner's office. I do as many as a dozen postmortems a day. I have a special assignment. I examine the bodies of junkies found dead under suspicious circumstances. We are trying to get an idea of just how many are being killed by pushers giving them uncut heroin when they have no further use for that particular addict.*

* Few people are aware of the fact that New York City has no fewer than some 100,000 heroin addicts. A dollar's worth of heroin is sold to each and every one of them for something like $20.00. To raise this sum, each and every dreary day of his life, the hooked habitue must panhandle, burglarize or purse snatch something like $100.00 worth of merchandise! These figures add to something like $10,000,000 worth of crime *daily*. In a year, the total is a staggering 3.5 BILLION dollars! And the Mafia dominates this frightful, lucrative racket! The best brains of the country are in the process of debating as to whether laws should be passed making drug habituation a *disease* treatable at appropriate centers. But this is another story.

"Well! just this morning, I was called upon to do an autopsy (and take appropriate tissue samples re narcotics) on a floozie found dead in a whorehouse just off "Needle Park." She was still not quite of age but—my, oh, my—faded, withered, several teeth knocked out and, of course, needle marks all over: the usual, wasted derelict.

"But, then: I looked at the abdomen and recognized my stitching! I took a hard second look at that face and—by Jove—I was looking at the wreck of Sharie! And she had not even changed her name; the band around the corpse's wrist carried, "Sharie Shell."

"Yes! She'd had V.D. and a couple of abortions and—yes, indeed—she had been killed in the all too usual way. Still, I opened the abdomen to take a good look at that Silastic prosthesis I had helped Dr. M. insert into that blown out hypogastric artery. It was just perfect! Completely secure and functional!

"Nevertheless, Dr. L.! Let us revert to the discussion on our *duties* as doctors that we had these many years back. You were expounding the etymology of the word, duty, and the obligations that are implied. Well, we doctors did become Sharie's guardians because her own parents had disowned her. They said that she had become *possessed* of an evil spirit: a sort of a poltergeist; this needed exorcizing. Why did not her court appointed guardian—i.e., we medicos—call in a witch doctor or a conjurer of some sort? We lost all interest after her recovery, physically. Had our responsibilities really terminated?"

The young colleague was speaking in dead earnest. I could see that he had been genuinely shaken by the morning's events. Actually, I had no convincing answer. Do you? ◄

1270 Fifth Ave.
New York, N.Y. 10029

The Arthritis Foundation salutes the thousands of dedicated physicians who volunteer their services in the nation's fight against crippling arthritis.

The Arthritis Foundation is the sole national voluntary health agency committed to conquering the rheumatic diseases. It provides the means for dynamic partnership between physicians and laymen to marshal leadership and resources toward the solution of this major national health problem.

The Arthritis Foundation looks forward to rapid growth with increasing opportunity for physicians to participate in the arthritis movement. For further information about The Arthritis Foundation and its programs write to the Foundation chapter in your community or to the Medical Department, Box 2525, New York, N.Y. 10001.

Floyd B. Odlum
Chairman of the Board

William S. Clark, M.D.
President

Donald F. Hill, M.D.
President of the American
Rheumatism Association Section

William E. Reynolds, M.D.
Medical Director

choose an experienced candidate—
millions of doses prescribed

Benadryl®
(diphenhydramine hydrochloride)

The White band on Pink capsule combination is a registered trademark of Parke, Davis & Company.

Supplied in various dosage forms including Kapseals®, containing 50 mg. of diphenhydramine hydrochloride.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

47968

No two women are quite alike...

and no other oral contraceptive is quite like Ovulen-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

The progestin is distinctive, and for some women this may mean a different clinical response. The Compack® tablet dispenser is distinctive; its functional simplicity makes it virtually patient-proof. The acceptance of Ovulen-21 is distinctive... together with Ovulen®, it is more often prescribed than any other individual contraceptive product currently available.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

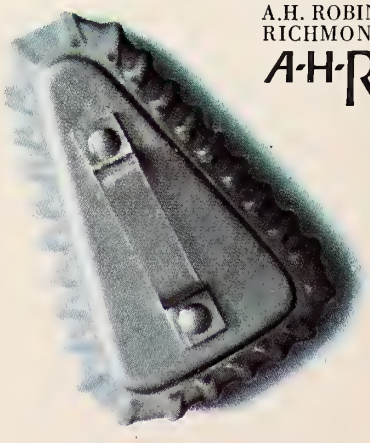
SEARLE Where "The Pill" Began
G. D. SEARLE & CO., P. O. Box 5110, Chicago, Illinois 60680

Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done... in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220
A·H·ROBINS

in sinusitis, colds, U.R.I.
Dimetapp® Extentabs®
(Dimetane® [brompheniramine maleate], 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)
up to 10-12 hours clear breathing on one tablet



ELECTROCARDIOGRAM OF THE MONTH

Concealed Digitalis Toxicity

CHARLES FISCH, M.D.
*Indianapolis**

THE two well known properties of digitalis are (1) depression of atrioventricular (A-V) conduction and (2) in toxic doses, enhancement of automaticity with appearance of ectopic rhythms. The usual course of events, when using digitalis in the management of atrial fibrillation, is one of gradual depression of A-V conduction with a resultant slowing of the ventricular rate. Ordinarily only toxic doses tend to evoke arrhythmias. In a small group of patients, however, the usual sequence of events may be reversed, namely enhanced automaticity (ectopic arrhythmias) may appear before any significant slowing of the ventricular rate is attained. Classical examples of such clinical situations include thyrotoxicosis, intercurrent infections, pulmonary embolization, postoperative states and intractable heart failure.

In some patients, because the supraventricular rate is more rapid than the "toxic" ventricular focus, the latter may not be evident either at the bedside or in the routine ECG. Consequently digitalis may be continued with potentially disastrous results. It is only when the supraventricular rate is slowed below the rate of the ectopic ventricular focus that the latter becomes obvious. Carotid stimulation is a time honored method of slowing the supraventricular rate. More recently Tensilon® has been proposed and used by some to slow the ventricular rate in atrial fibrillation. Both maneuvers slow A-V conduction by potentiating the vagal effect at the A-V junction.

An example of hidden toxicity unmasked by small doses of Tensilon® is shown in Figure 1. The top row shows an atrial fibrillation at a rate of about 100 per minute. Following intravenous administration of Tensilon®, the ventricular

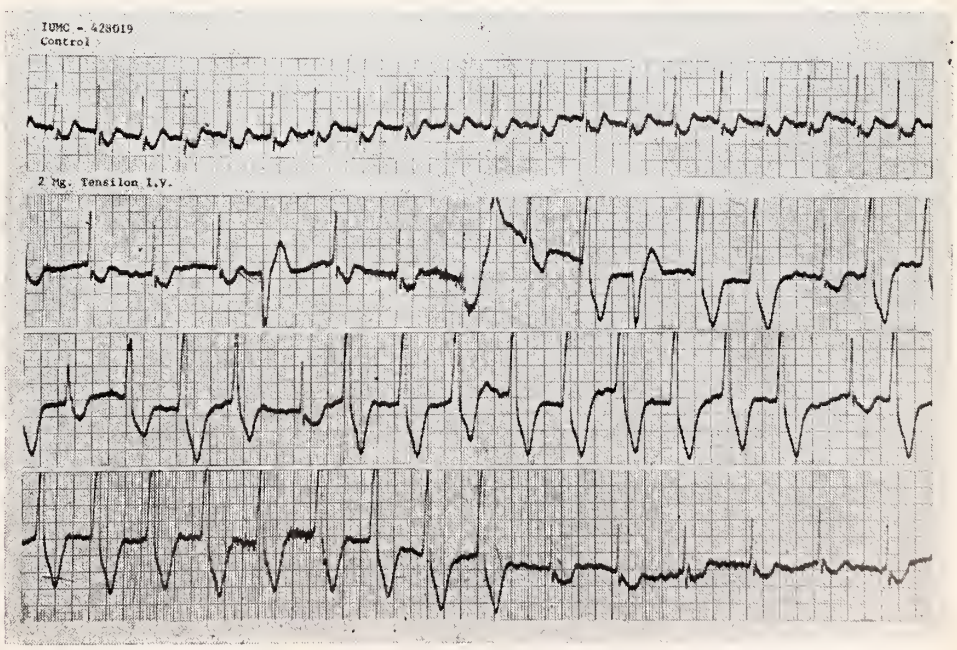


FIGURE 1
VENTRICULAR tachycardia unmasked with Tensilon® (for details, see text).

* From the Krannert Institute of Cardiology, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.

rate slowed to about 75 and at that point a ventricular tachycardia with a rate of about 90 appeared. The tachycardia is intermittent and interrupted by supraventricular conduction. Two ventricular premature beats of a different morphology, not an infrequent finding during digitalis toxicity, are seen in row 2.

The ventricular tachycardia is followed by supraventricular complexes which are absolutely regular, suggesting a junctional (A-V nodal) tachycardia, another arrhythmia most often indicative of digitalis toxicity.

The above described situation is encountered frequently enough to make it clinically important. It is obvious that continued administration of digitalis to this patient in an effort to slow the ventricular rate might have resulted in serious if not fatal arrhythmia. ◀

REPORT OF THE BOARD OF TRUSTEES

Report: C
(A-68)

Subject: AMA Posture on Public Comment

Presented by: Wesley W. Hall, M.D., Chairman

Referred to: Reference Committee F
(William B. Rawls, M.D., Chairman)

The Board is cognizant of the great increase in attention being given in the press and broadcast media to medicine and health care. Our profession is now the focus of one of America's greatest interests. It will constantly be in the spotlight, ending the professional reticence and privacy in which medicine functioned most of the time in the past.

Even though this interest is a tribute to the importance of medicine and the public's desire for its benefits, it brings with it the problems facing any person or organization with a key public position: much of the coverage is critical or displays a lack of understanding.

The Board of Trustees has consulted with AMA staff and public relations counsel on this increasingly important situation. The conclusions that have resulted from this intensive and thoughtful consideration are submitted now:

1. When statements about medicine are misguided or unfair, corrective statements will be issued promptly when the facts are available and an orderly response is possible.

2. We must recognize that the prominence and complexity of medicine in the United States today result in many limitations. Medicine is a constant subject of news and comment, much of which cannot be subject to a later response. Often our replies cannot be carried by the broadcast medium or publication, or at best will be much less prominent than the original coverage. Quite often a responsible statement cannot be issued until the facts have been obtained, and these may be scattered about the country or involve a local situation or require a great deal of time.

3. The frequency and complexity of these matters have increasingly diverted the officers and staff of AMA to reacting to what others do and say. This decreases the ability to work on constructive, ongoing activities that are vital to our future.

4. Staff is developing in written form the best possible anticipatory statements regarding all foreseeable circumstances. By having such matters thought out and documented when a need arises, we will be able to reduce the instances of surprise, decrease the time required for response, and assure consistency in AMA statements on these matters.

5. We will concentrate on building a positive posture by getting understanding for medicine's functions and its positions on various considerations; and by educating the press, broadcasters and opinion leaders. This will help forestall much misguided criticism and build a favorable climate that will inoculate against susceptibility to unfair criticism.

6. All state and county medical societies are urged to follow these same procedures.

You will see many instances in which AMA responds to public comment, many in which we have acted but our effectiveness will be in correcting the source and may not be visible immediately, and instances when judgment indicates a response should not be made. In each case the best judgment and skills will have been applied to the complexities of the situation.

"Mad as a wet hen"

over your

P. D. A.?

(Past Due Accounts)

Let the **Associated Credit Bureau** member in your area calm you down by collecting your P.D.A. (Past Due Accounts). Simply stated, we specialize in collecting delinquent accounts for physicians, dentists, hospitals and laboratories. Our staff members are expert in collecting while preserving the vital patient relationship. If you have P.D.A. (most professional people do)—let us prescribe the remedy.

TO CALM YOUR MIND ON P.D.A.
CALL US TODAY!

Associated Credit Bureaus

OF INDIANA

affiliated with

ASSOCIATED CREDIT BUREAUS OF AMERICA

Contact your local ASSOCIATED CREDIT BUREAU OF INDIANA *member*

X-RAY CONFERENCE

Changes of the Diploic Space Secondary to Anemias Mimicking Intracranial Lesions on Technetium Scintiscanograms

*PATRICK E. SEWELL, M.D.**
*ERICH K. LANG, M.D.***
Shreveport, La.

A 14-year-old colored female, with known sickle cell disease, was admitted to the Confederate Memorial Medical Center for workup of seizure activity of two days duration. The patient had been hospitalized two weeks earlier for treatment of pneumonia and sickle cell crisis, at which time she received two units of whole blood. Temporal headaches were reported to have been present since that discharge. Two days prior to admission, the patient experienced a bizarre seizure, after which she had right upper extremity weakness, mental confusion and motor aphasia. Physical examination, on admission, revealed the characteristic physical features of sickle cell disease, right upper extremity weakness and slight mental confusion. A CBC showed hemoglobin 7.6 grams, hematocrit of 25% with moderate target cells reported on the peripheral smear. Hemoglobin electrophoresis was reported as 40% hemoglobin S and 60% hemoglobin A, the latter reflecting the previous transfusion. Lumbar puncture revealed normal pressure, chemistries and cell blocks. EEG was reported as grossly abnormal.

Strongly suspecting an intracranial lesion with vascular thrombosis, an AP and lateral brain scintiscanogram was obtained, using Technetium 99M (Figure 1). Increased activity was demonstrated over a large area of the vertex. The diagnosis of a subdural hematoma was considered, however, correlation to the plain skull film suggested the changes to be secondary to pooling of radioisotopes in a prominent diploic space occasioned by proliferation of the hematopoietic tissue. The plain skull roentgenogram (Figure 2) demonstrated the typical "hair-on-end" appearance seen with

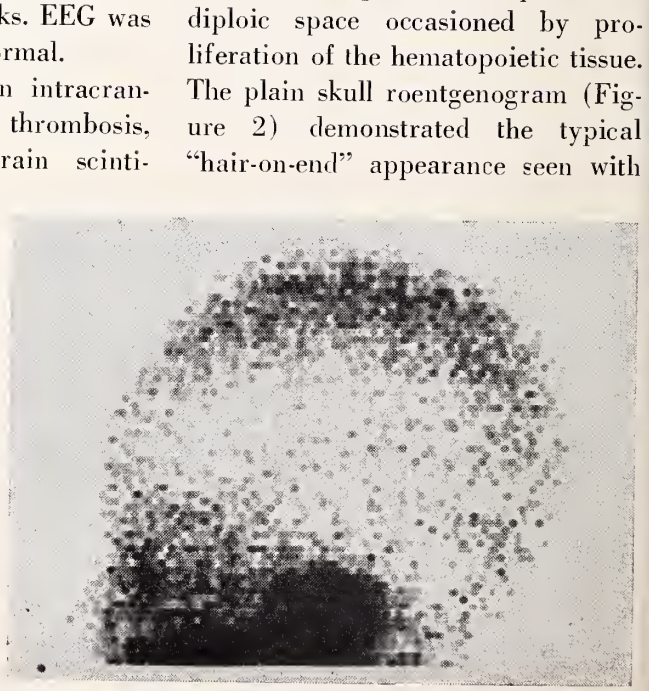


FIGURE 1

THE scintiscanogram demonstrates a marked increase of radioisotope concentration over the entire vertex mimicking an extensive parietal lesion. Note the close correlation of the increased uptake to the maximal osseous changes demonstrable on the plain skull roentgenogram.

* Senior Resident, Department of Radiology, L. S. U. School of Medicine, Confederate Memorial Medical Center, Shreveport 71106.

** Professor and Chairman, Department of Radiology, L. S. U. School of Medicine, Confederate Memorial Medical Center, Shreveport 71106.

hemolytic or chronic iron deficiency anemia, the osseous changes reflecting widening of the interdiploic trabeculae, secondary to proliferation of hematopoietic component.

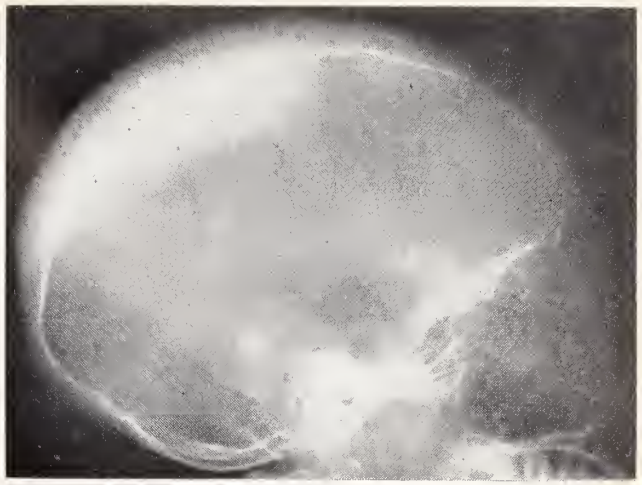


FIGURE 2

THE lateral skull roentgenogram demonstrates the typical "hair-on-end" appearance of the parietal bones diagnostic of the changes seen with certain anemias.

Discussion

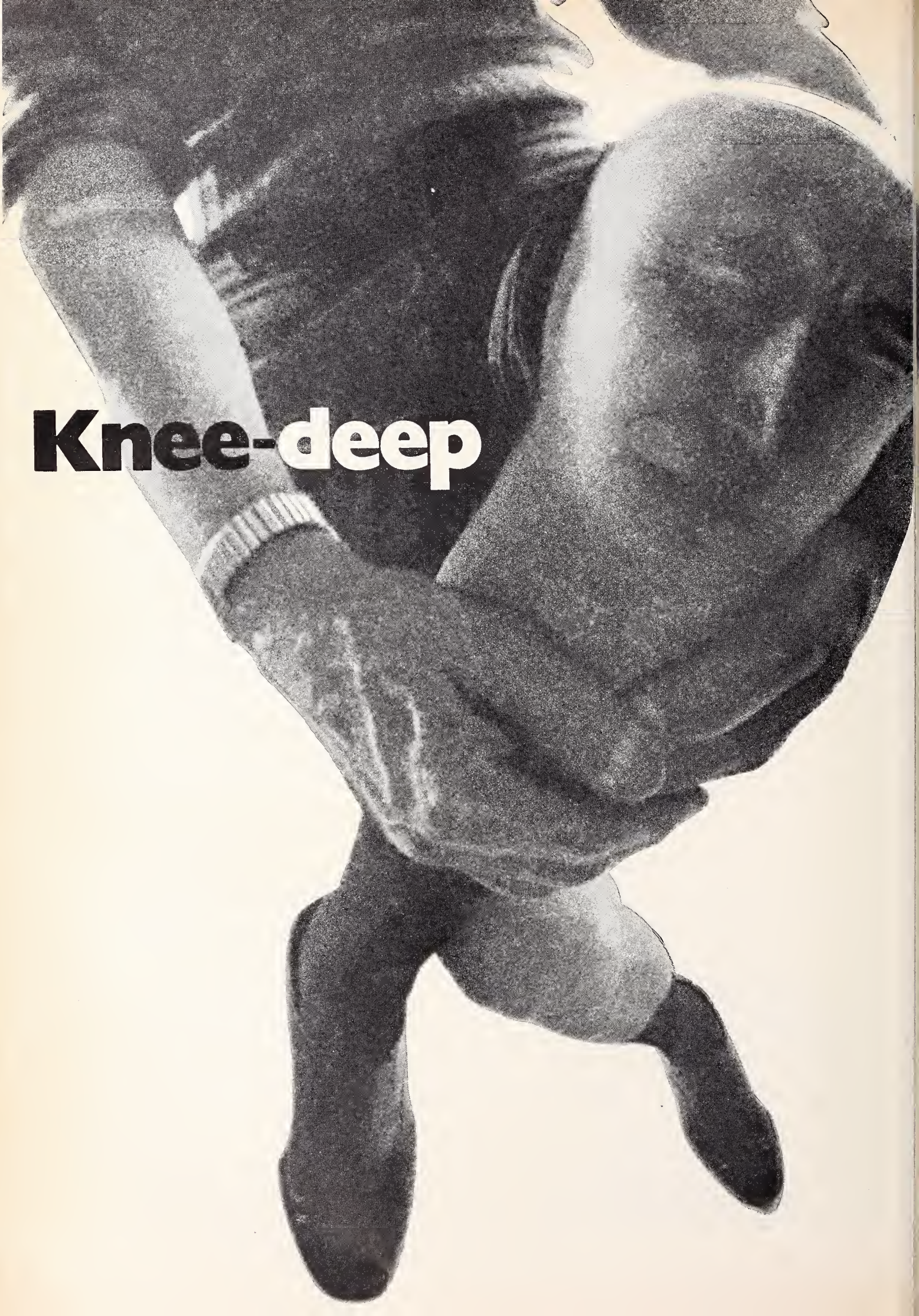
Scintiscanograms demonstrating areas of increased uptake may often cause the erroneous interpretation of an intracranial lesion. The reported case is cited as an example of extracranial pathology, occasioning this appearance. Lesions of the calvarium causing an increased vascular space and volume in the diploic space, such as Paget's disease, an arteriovenous fistula, hypervascular metastatic neoplasia and certain anemias, occasioning increased proliferation of the hematopoietic system and hence, the volumetric enlargement of the diploic space, classically cause this increased concentration of radioisotope. Certain soft tissue lesions and infection in the subgaleal space may likewise result in increased concentration of Technetium 99M and simulate an intracranial lesion. The problem is most often dissolved by correlation to the plain skull roentgenogram and scrutiny of the soft tissues on various projections of the plain skull roentgenograms. Characteristic soft tissue changes and localized bulging of the soft tissue components, as well as characteristic roentgenographic osseous changes will usually permit a definitive diagnosis of these entities. Comparison to scintiscanograms with other radioactive products can be utilized for the differential diagnosis. RISA scintiscanograms are particularly useful for the assessment of an increased vascular space, such as seen in Paget's disease, hypervascular metastatic neoplastic lesions and increased diploic space, secondary to proliferation of the hematopoietic tissues. Strontium 87M likewise exhibits a predilection for osseous lesions and can, therefore, be utilized in differentiation of lesions of the brain and meninges. ◄

Pamphlets Available on Drugs

Because of the rising incidence of drug abuse in the United States, especially among young people, the American Medical Association has published five related pamphlets, "Amphetamines," "Barbiturates," "Marihuana," "LSD," and "Glue Sniffing."

Written originally for the 1968 Community Health Week program on drug abuse, the one-page pamphlets answer many of the questions frequently asked about this growing problem. In addition to describing the effects of these dangerous substances on the body, each pamphlet stresses the hazards of experimentation, the psychological effects on the users and the legal controls.

Review copies are available from the AMA's Department of Health Education. Quantity copies are available from Order Handling at 15 cents each; 50-99 copies, 14 cents each; 100-499 copies, 12 cents each; 500-999 copies, 10 cents each and 1,000 or more copies, 8 cents each.


Knee-deep

in osteoarthritic pain

If aspirin doesn't help, move in with Tandearil.

The trial period is brief: 1 week. Try one tablet q.i.d. at first. Tandearil usually starts working within 3 to 4 days. When response occurs, as little as 1 or 2 tablets daily may hold back pain and stiffness, and increase joint motion.

On the next page is a summary of adverse reactions, contraindications, warning and precautions.

Tandearil.
It can help get his mind off his knee.

Please review full Prescribing Information carefully before prescribing.

For osteoarthritic knees, spines, shoulders, hips, etc.:

Tandearil®
oxyphenbutazone

Tandearil, oxyphenbutazone:
For brief summary see next page.

Geigy

TA-6006

Tandearil®
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

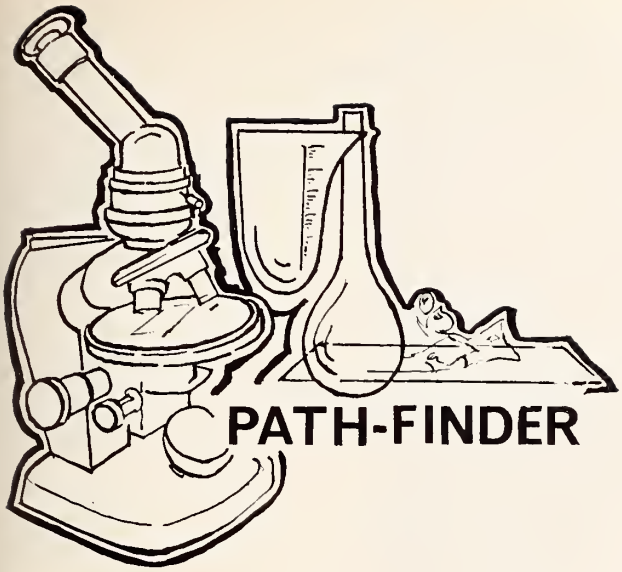
Dosage in Osteoarthritis:
Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.
(B)R-46-800-A

For complete details, please see full Prescribing Information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502



This series is intended to emphasize the importance of judicious selection and proper interpretation of newer laboratory procedures as applied to differential diagnosis of various diseases. It is edited by Leon L. Blum, M.D., Terre Haute.

Pre-diabetic Glucose Tolerance Curve

H. P. PALMER, M.D.
*Franklin**

A 30-year-old female presented a typical "pre-diabetic" curve, employing the standard glucose tolerance test. The fasting blood sugar was 80 (normal 80-110 mg %); one-half hour level 171 mg%; one hour level 157 mg %; two hour level 157 mg %; and three hour level 144 mg % (Figure 1). Thus the patient had a rather common type of curve associated with the pre-diabetic condition. Because of the fact that she was actually underweight rather than overweight and there was no family history of diabetes, the question arose as to whether this was truly a pre-diabetic curve.

Further history revealed that the patient had undergone gastrointestinal x-rays and gallbladder x-rays two days immediately preceding the glucose tolerance test. With this history in mind, it was suggested that the patient most likely manifested a false pre-diabetic curve due to the low carbohydrate intake preceding the test.

The standard glucose tolerance test was repeated after the patient had eaten a 250 gram carbohydrate diet daily for three days. A repeat glucose tolerance test revealed values of 77 mg % fasting blood sugar; 139 mg % in one-half hour; 148 mg % at one hour; 100 mg % at two hours; and 100 mg % at three hours (Figure 2). As can be seen, this was a perfectly normal glucose tolerance curve and the first curve was abnormal due to a poor carbohydrate intake preceding the test.

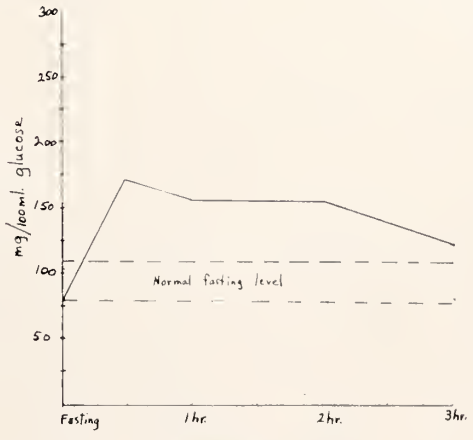


FIGURE 1
INITIAL glucose tolerance curve.

The pre-diabetic curve obtained by glucose tolerance testing in a patient on low carbohydrate intake is usually attributed to a temporarily decreased glucose tolerance. It must be borne in mind that a "pre-diabetic" glucose tolerance curve may be obtained in conditions other than the pre-diabetic state. Perhaps the most common cause of a false "pre-diabetic" curve is an insufficient carbohydrate intake two or three days preceding the test, but other causes include previous gastric surgery, pregnancy, endocrine disorders and certain medications (ACTH or hydrocortisone).

Many types of glucose tolerance tests have been devised and the most commonly used is the standard glucose tolerance test with blood sugars up to three to four hours following glucose ingestion. The simplest and most convenient glucose tolerance test is a two hour

* Pathologist, Johnson County Memorial Hospital, Franklin 46131.

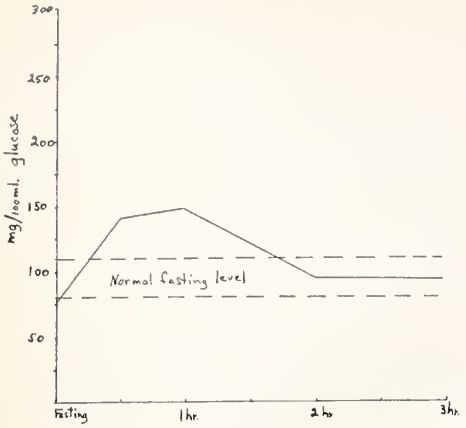


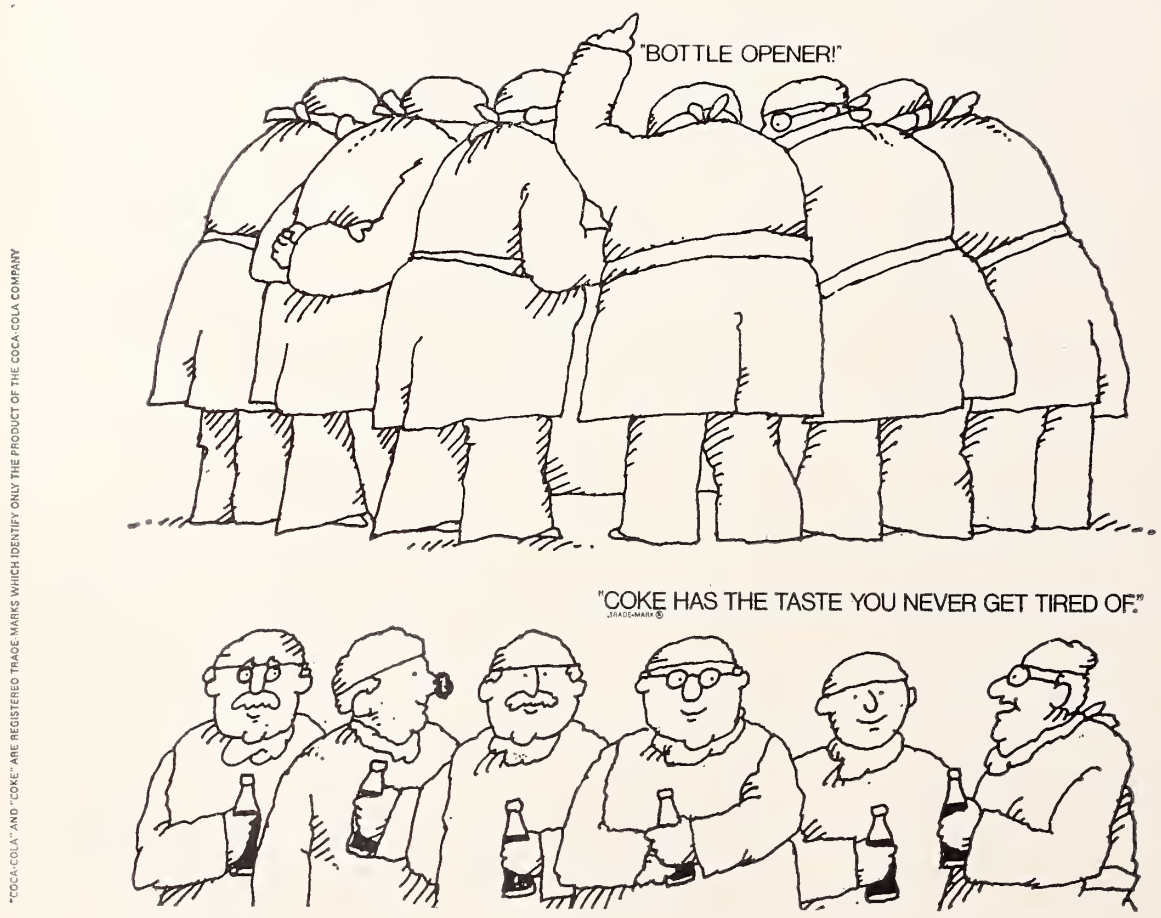
FIGURE 2
GLUCOSE tolerance curve following ingestion of 250 gms. carbohydrate per day.

postprandial glucose following a 100 gram carbohydrate breakfast. This determination coupled with a fasting blood sugar level usually will suffice in most instances to rule out pre-diabetes or mild diabetes. The glucose tolerance test or the postprandial glucose is relatively useless unless the patient has ingested at least 250 grams of carbohydrate per day for at least two or three days prior to the test. The standard glucose tolerance test should be reserved for those persons who are overweight or who have a family history of diabetes and those individuals with glycosuria or an inconclusive two hour postprandial glucose test.

The glucose tolerance test has little value in establishing the diagnosis and is more important to rule out diabetes or pre-diabetes. ◄

REFERENCE

1. Hoffman, W. S.: *The Biochemistry of Clinical Medicine*, Ed. 2, Chicago, 1959.



When it's more than a bad cold

your patient can feel better while he's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

348-B

The Journal
of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 1802 North Illinois Street, Indianapolis, Ind. 46202.

Associate Editors: A. W. Cavins, M.D., 221 South Sixth Street, Terre Haute; Lall G. Montgomery, M.D., Ball Memorial Hospital, Muncie; David A. Bickel, M.D., 515 Odd Fellows Building, South Bend; Samuel R. Mercer, M.D., 702 Medical Center Bldg., Fort Wayne; I. W. Wilkens, M.D., 1743 Shelby St., Indianapolis.

Editorial Board:	Term Expires
Alvin J. Haley, M.D., Fort Wayne	Dec. 31, 1968
Wei-Ping Loh, M.D., Gary	Dec. 31, 1968
Jack W. Hickman, M.D., Indianapolis	Dec. 31, 1969
Frank H. Coble, M.D., Richmond	Dec. 31, 1969
Jene R. Bennett, M.D., South Bend	Dec. 31, 1970
W. D. Snively, Jr., M.D., Evansville	Dec. 31, 1970

Assistant Editor: Jackie Freers Stahl
Business Manager: James A. Waggener
3935 N. Meridian, Indianapolis, Indiana 46208.

Army MUST System Improves

THE Medical Department of the U. S. Army, in celebration of its 193rd anniversary, devotes considerable space to a report on the further development of the field hospital equipment which was first placed in service in 1965.

"MUST" (Medical Unit Self-Contained Transportable) was originated as a series of inflatable shelters with utility systems to supply electricity, air conditioning, heating, water and waste disposal. The unit may be packed in a relatively small package for transportation by an Army 2½ ton truck or by helicopter.

Experience in combat since 1965 has developed a number of improvements and refinements in the MUST system. The following is quoted from the Medical Department's Report:

The new concept in field medical hospitals is a quickly assembled, air-conditioned, go-everywhere unit called "MUST." MUST, (Medical Unit, Self-Contained, Transportable) operations, which began in 1966 have expanded in number to six. The original unit, the 45th Surgical Hospital, has been joined by the 3rd, 18th and 22nd, in supporting the Army. Two other MUST units support the U. S. Marines.

Improvements to the already independent units have made MUST even more flexible.

Development and performance testing of the MUST food service was completed this year. The primary function of the Food Service System is to service evacuation and surgical hospitals. The service consists of main kitchen facilities, dining hall, ward food service area and sanitizing facilities. The dining hall, able to accommodate 120 in one sitting, utilizes cafeteria methods. The ward food service area is in a patient service element and provides for distribution of food to 40 bed patients.

The engineering and service testing of the pharmacy has been completed. Air-conditioned, it is capable of supporting a 400 bed evacuation hospital, or 60 bed surgical hospital for 48 hours without restocking. Storage, scientifically engineered, is available for safekeeping of every type drug. Another feature of the new pharmacy is the ability to produce both distilled and deionized water necessary for drug mixtures.

The Dental Oral Surgery is housed in a similar structure, and includes a functional layout of equipment to form a two-chair dental operating clinic, with complete waiting room and x-ray facilities. A dental lab is equipped to repair dental prosthetics appliances and to do limited fabrication.

Water supply will no longer be a problem to MUST. The Army has done the impossible by the use of sanitary water recycling systems. The system includes toilets, showers, lavatories, a water treatment unit and a water purification unit, in addition to a large mobile incinerator consuming all material, including pathological wastes. A prototype of shower, toilet and lavatory is expected to be delivered this month. Large incinerator, water treatment and water purification units are due for delivery in December, 1968.

22nd AMA Clinical Convention

AT no time in medical history has there been such an explosion of scientific knowledge and technology. And never has there been a greater demand for physicians' services.

These factors combine to burden the busy physician in his efforts to keep abreast of the modern developments in medicine.

There is an abundance of fine scientific publications, but many

hours of reading would be required to learn what can be gained by attending the Clinical Convention of the American Medical Association. It will be in Miami Beach, Fla. Dec. 1-4.

There will be 125 exhibits there reflecting the latest developments in pharmaceuticals, medical equipment and scientific endeavors.

The Clinical Convention—this will be the 22nd—is one of the best ways of providing continuing education to the busy physician. The scientific exhibits alone are a good postgraduate course in medicine.

And special postgraduate courses will be offered, too, in diabetes, fluid and electrolyte balance and thyroid disease. In addition, there will be about 30 medical motion pictures and scientific television programs will be shown live and in color.

For the physician who likes to discuss the intricacies of his profession, there will be clinical workshops and four breakfast roundtables.

The AMA Clinical Convention is designed primarily for the man in practice. The speakers will read papers that will bring to the practitioner the latest findings of others in his area.

There is an unprecedented emphasis on and need for continuing education. A great manpower shortage has made it mandatory for the physician to expand his knowledge and become more versatile.

The Clinical Convention promises to be a stimulating four days, worthy of the busy physician's time. Every physician is urged to take advantage of this educational opportunity.

The Promised Second Misconception

I knew that the old grouch was waiting for me as soon as I entered the staff room. When I saw him last, he had promised to expound upon a second major misconception in health care planning.

"Another major inconsistency," he began, "is that we physicians speak frequently about the need to reduce health care expenditures, yet we, and others, are pursuing a course that is bound to increase these costs."

"That sounds inconsistent," I agreed, "but you'll have to be more specific."

He readily agreed to this. He cited as his primary example the actions of voluntary health organizations and organized medicine to increase public awareness in health. It did seem true that every time one turns around, he is beseiged by these organizations to have one part or another of his body checked over to be sure that it doesn't have some dread disease or other. I immediately thought of a recent public service message on the radio that exhorted its listeners to guard against schizophrenia personally and to look for it in one's family. The old grouch went on to suggest that medicine was using the same Madison Avenue techniques of creating demand that have been well documented in commercial enterprise.

"You're not telling me that we should advise people to neglect their health are you," I asked.

"Not at all," replied the old grouch. "I'm merely saying that it is an inconsistent position to favor increased consumption of a service coupled with decreased expenditures for it." He opined that we were also saying that there is a nation-wide shortage of physicians and at the same time we're telling the citizenry that they need to see their physicians more often. If that does nothing else, it makes the physicians more overworked.

"In my book, that's also an inconsistency," he grumbled, as he slouched out of the staff room.

I had to agree.—J.W.H.

Guest Editorial

Are You Safe At Home?

HALF of all the blind in the nation today are victims of a needless tragedy, claims the Indiana Society for the Prevention of Blindness. In addition to those cases due to the neglect in getting an early diagnosis and proper treatment of eye diseases, many are because of accidents.

According to latest data from the Public Health Service's National Health Survey, more than 40% of the accidents causing vision impairment in the U.S. today occur in the home. This represents a greater number than the combined number of at-work and automobile accidents in which eye injuries are sustained.

This high incidence of home eye injuries is due to carelessness because people just haven't learned to take industry, school and automobile safety habits and attitudes home with them.

To remedy this situation, the Society recommends that all members of the family wear all-purpose safety goggles when mowing lawns (especially with power mowers), burning trash, pruning bushes, spraying plants with insecticides and while spreading chemical fertilizers. For proper safety goggles for around the home and garden, a local optical equipment center may be consulted.

The Society also warns against throwing glass bottles, used batteries, empty spray cans on trash fires. which can cause them to explode, showering glass and metal and caustic chemicals.

Everyone who wears glasses should wear safety glasses, especially children and senior citizens who are exposed to more and new home eye accident hazards.

Little League baseball recommends that all of their boys who wear glasses should wear safety glasses.

The Society urges parents to keep aerosol sprays containing pressurized

liquids, such as deodorants, antibiotics, oven cleaners, paints and hair sprays out of the reach of children at all times. It also warns parents that 17% of the more serious injuries to children's eyes are caused by missile-type toys such as pellet guns, dart guns, air guns, bean shooters and toys having protruding points and sharp edges.

If we put to full use the scientific and safety knowledge already available, half of all blindness can be prevented. By following these eye-safety recommendations, you and your family can be safer at home.—**Indiana Society for the Prevention of Blindness.**

Editorial Notes . . .

Hospital patients over-65 produced an increase in rate of admission to community hospitals by 8.4% during the first quarter of this year. During the same period the admission rate for under-65 decreased by 0.5%. Those over-65 accounted for 20.6% of all admissions and 33.3% of inpatient days.

Vehicle inspection will begin early next year in Indiana. A Certificate of Rejection will be placed on each vehicle which requires repair or adjustments. It will be illegal to drive a rejected vehicle except to return it to the residence or place of business of the owner or to drive it to the place of repair and return to the Inspection Station.

Dr. W. U. Kennedy, New Castle, has established a scholarship at McMurray College in Jacksonville, Illinois, in honor of his wife. It will be known as "The Sada Vertrees Kennedy Scholarship." Mrs. Kennedy was valedictorian of the McMurray College Class of 1899. The school, now over 100 years old, is known as the "Vassar of the West." The scholarship, large enough for two students, is intended to help Illinois girls who will major in economics and foreign relationships.

How man can prevent crises in his environment instead of constantly being surprised and overtaken by them will be the subject of a variety of research and educational projects for which grants have been announced by the Ford Foundation. Totaling nearly $4 million, the grants will finance such activities as research on the effects of overcrowding on human physical, social and psychological makeup, a case study of the potential impact of weather modification proposals on grassland vegetation and the use of computers to study activities ranging from the management of fish to population pressures on urban transportation.

Dr. Francis L. Land has disavowed the quotation ascribed to him in the May 13 issue of *Medical Economics* to the effect that Title XIX legislation requires two-thirds of a state's physicians participate in the program by 1970 or the state will lose Federal funds. The Medicaid Law does state that states that do not have Medicaid programs in effect by January 1, 1970, will lose Federal matching funds for expenditures for medical care as part of their aid to families with dependent children and the needy aged, blind and disabled.

Great Britain, which has long lamented the fact that its scientists and especially its young doctors were moving to the U. S. in outlandish numbers, is taking comfort from a recent change in United States immigration policy. Recently the quota system was abolished and we now will admit up to 120,000 persons from the western hemisphere and up to 170,000 from the eastern hemisphere on a worldwide basis. The policy will be "first come, first served"—visas will be issued according to the date the application is made.

Physician opinion poll by Marion Laboratories' PLAYBACK indicates that 61% of the physicians participating would discontinue financial support of a son or daughter who became involved in a campus riot; only 19% would continue support. Additional suggestions such as: "Put him to work", "Disown him" and "Send him to a psychiatrist" were offered.

Arthur D. Little, Inc. (ADL), of Cambridge, Massachusetts, has contracted with the Public Health Service to evaluate a range of home-care apparatus for dialysis. It is estimated that, during the last eight years, only 2,200 of the estimated 60,000 possible candidates for dialysis have had the benefit of the treatment. Despite the high cost, technics are now sufficiently routine to permit home treatment without attendance of medical personnel. ADL will seek to determine the best equipment in terms of performance, safety and cost. ADL will also identify the hazards of home use and will recommend, if possible, improvements to existing equipment.

The Medical College of Georgia and the National Cash Register Company have adapted a computer for monitoring and analyzing the incidence of tuberculosis and for recording treatment results. Patients with active disease and their contacts are registered in the memory unit by the punch card method. Appointment letters are written by the computer and clinic schedules are made daily. The computer can review and update 500 records, prepare the schedules and write the necessary letters in 12 minutes. Data for each clinic visit are entered into the memory bank; progress reports can be obtained on all patients at any time. NCR thinks the system is applicable to other disease states also. ◄

Dilantin®
(diphenylhydantoin)

PARKE-DAVIS

In untold thousands of epileptic patients... Dilantin has been, and continues to be, the bedrock of therapy.

DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anticonvulsant drugs.
PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. ADVERSE REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred.
DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.
Parke, Davis & Company, Detroit, Michigan 48232

The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium.

PARKE-DAVIS 015R67

President's Page

With humility I pay tribute to the leadership of all those who have preceded me as president of the Indiana State Medical Association — men whose wisdom has been responsible for the creation and growth of one of the finest and most outstanding state medical associations in our country.

With pride I acknowledge the ability and the unbelievable amount of time and effort expended in the performance of their duties by the officers of our association — the Executive Committee, under the chairmanship of Dr. Ralph Everly; the Council, under the leadership of Dr. Lowell Steen; the staff of our *Journal*, under the editorship of Dr. Frank Ramsey; the members and chairmen of the commissions and committees; the officers and the members of our component county societies.

Especially do I commend the Commission on Convention Arrangements and the members of the host Allen County Society for their efforts in preparing the program for this year's annual convention.

With gratitude I recognize the excellence of the Indiana University School of Medicine and its faculty, under the leadership of Dean Glenn Irwin.

With thanksgiving I honor our headquarters staff — Jim Waggener, Kenneth Bush, Bob Amick and Howard Grindstaff, together with the office help for performance far beyond the call of duty.

Truly the accomplishments of this past year have been a team effort. It has been a most rewarding experience to serve as your president and I wish to express my heartfelt appreciation for your gracious help.

And now, speaking for every member of ISMA, I pledge the utmost cooperation to our incoming president, Dr. Patrick J. V. Corcoran, an excellent clinician, a gentleman in every sense of the word, knowledgeable in the affairs of medicine — a man of outstanding ability and great wisdom. Good luck, Pat.

G. O. Larson M.D.

"Man's best friend" in wintertime diarrheas

In winter "flu" and viral gastroenteritis, Donnagel (4 oz. size!) can bring aid and comfort to sufferers from both diarrhea and its discomforts because it contains kaolin and pectin plus belladonna alkaloids (as in Donnatal®). Donnagel treats the whole diarrhea problem. Available on your prescription or recommendation. A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

CLEAR THE TRACT!
ROBITUSSIN®

THERE'S A FORMULATION FOR EVERY COUGHING NEED

All the Robitussins contain glyceryl guaiacolate, the outstanding expectorant agent that greatly increases the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheo-bronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"
ROBITUSSIN®
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Alcohol, 3.5%

For unproductive allergic coughs
ROBITUSSIN® A-C
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Pheniramine maleate . . . . . 7.5 mg.
Codeine phosphate . . . . . 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hour cough control
ROBITUSSIN®-DM
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Dextromethorphan hydrobromide . 15.0 mg.
Alcohol, 1.4%

Clears sinuses and nasal stuffiness as it relieves cough
ROBITUSSIN®-PE
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Phenylephrine hydrochloride . . . 10.0 mg.
Alcohol, 1.4%

	ROBITUSSIN	ROBITUSSIN A-C	ROBITUSSIN-DM	ROBITUSSIN-PE
EXPECTORANT	●	●	●	●
DEMULCENT	●	●	●	●
COUGH SUPPRESSANT		●	●	
ANTIHISTAMINE		●		
LONG-ACTING (6-8 HOURS)			●	
NASAL, SINUS DECONGESTANT				●

PHOTO BY VICTOR HAND

A. H. Robins Company, Richmond, Va. 23220

A-H-ROBINS

Aspirin

JESSIE M. STEVENSON
Indianapolis

THE usefulness of aspirin was unknown to the medical profession until about 50 years after its discovery in the laboratory. This drug, often referred to as "king of all miracle drugs," is — like so many other great discoveries — an outstanding example of the irony of fate. The chemist who synthesized the drug is now almost a forgotten man; and eventually when its therapeutic properties became known, the man who opposed it most, who called it of "no value" was given credit for its discovery and became wealthy as a result.

An article published in a leading pharmacological journal *Die Pharmazie* in 1949 established the fact that two chemists discovered the usefulness of aspirin. One of these was Arthur Eichengrun who wrote his memoirs concerning the discovery while in the concentration camp of Theresienstadt in 1944. The other chemist was his associate, Felix Hoffmann. It is interesting to note that in most current literature on the subject Hoffmann is referred to as the discoverer—Eichengrun is mentioned only occasionally.

Discovered in Germany

In 1895 Carl Duisberg, an industrial chemist connected with the J. G. Farkenindustrie, had asked Eichengrun to set up a scientific department at a newly established laboratory of the Bayer Company at Elberfeld, Germany.

It was here that these two chemists discovered the usefulness of aspirin in 1898. A year later, Heinrich Dreser, who had been appointed chief chemist and head of the Bayer Company's research department, unwillingly introduced aspirin into the medical world.

When Dreser accepted the position with the Bayer Company, his contract stipulated that no new products would be released to the medical profession without his approval.

The Bayer Company officials had ordered Eichengrun and Hoffmann to find a substitute for salicylic acid, a drug which produced many unfavorable reactions, among them nausea and tinnitus.

Hoffmann, however, had another good reason to find such a drug—his father suffered from rheumatism.

"Felix my rheumatism is bad again" sobbed Papa Hoffmann.

"Did you take your pills?" queried Felix.

"Don't talk pills to me; they make me sick. I'd rather have my rheumatism."

"They're good for you" replied Felix; "wonderful salicylic acid pills."

But Papa Hoffmann was greatly irritated by Felix's remark and said:

"Felix, I've given you a good education, now I want you to find something to ease my suffering and at the same time not make me sick."

"Someday I will find something for you" hopefully answered Felix.

Both chemists knew what they had to look for. They had to find a compound which could be added to salicylic acid, a drug which had been synthesized by the German chemist, Hermann Kolbe, that would make it bland enough for clinical purposes and at the same time not impair its pain relieving qualities.

What these chemists did not know was that an Alsatian chemist, Charles Frederic Gerhardt, had discovered what they were searching for in 1853, *Acetylsalicylic* acid. He had noted its laboratory name in a chemistry book and it had been forgotten, probably because no one took the time to test its usefulness.

A Chemical Freak

Hoffmann searched in vain through the scientific literature in an effort to find the needed compound. Finally, in desperation, he turned to records which had been relegated to a shelf containing books on chemical freaks and oddities. There he located the formula for acetylsalicylic acid, commonly known as aspirin, discovered almost a half century earlier.

Hoffmann prepared the formula under Eichengrun's direction. They excitedly took a sample to Dreser, their chief. Dreser was skeptical of the newly-unearthed preparation. Besides being a medical doctor, he was also a mathematician and physicist and held the theory that the effectiveness of any drug depended on how well it conducted electricity. Dreser said that acetylsalicylic acid seemed to be a poor conductor of

electricity and flatly rejected it. He would not allow it to be tested clinically, stating that the substance would be "poison to the heart."

Eichengrun, however, began to test it on himself. He sent some to Berlin doctors who tried it on their patients. They all found the drug to be a highly effective pain reliever and in no way harmful to the heart.

Eichengrun wrote a detailed report of his findings and sent it to Felix Goldman, representative of the Bayer works in Berlin, along with some of the drug. The chemist requested that Goldman give it to physicians he could trust for testing, since Dreser's resistance had made it impossible to experiment with aspirin officially.

Goldman gave the preparation to some physician friends and they soon reported no bad reactions to the drug among their patients. In fact, Goldman requested Eichengrun to send him larger amounts for more detailed tests, all of which proved to be quite satisfactory.

The primary effect of aspirin—pain alleviation—made it extremely popular. Goldman wrote a highly favorable report about the product to the administrator of the Bayer Company. This action created a great furor because Dreser was so unrelenting in his judgment.

Dreser was asked to study the report and state his opinion in view of the substantial evidence which had been accumulated in favor of the drug.

Dreser was still not convinced and wrote on the margin of the report: "That is the usual Berlin big mouth; the product has no value." It is possible that this report, bearing his inscription, may still be in the files of the Bayer Company.

Faith in Product

Eichengrun was determined, however, that this most useful drug should not be relegated to the chemical morgue for another 50 to 100 years of uselessness. He sought the help of Carl Duisberg, the man who had hired him at the Bayer Company. Duisberg agreed with Eichengrun and decreed that Dreser's judgment should be re-tested and that the product should be sent out officially for evaluation to a number of leading clinics and hospitals. This was done and all of the results were most favorable. As a result, leading chemists and physicians decided to introduce acetylsalicylic acid into medicine under the name that Eichengrun had given it—aspirin.

Dreser was assigned the task of writing the pharmaceutical introduction of the new product for its publication in a leading medical journal. Concerning the name given the drug (aspirin) Dreser said: "Nobody will know what it means but it will be so easy to pronounce."

Ironically, the publication of this article resulted in Dreser getting the credit for discovering the usefulness of aspirin and helped him to retire at an early age. Thus aspirin was officially born and Papa Hoffmann was afforded relief from his rheumatism.

The five-grain aspirin tablet has been called the physician's handmaiden. It is surmised that few physicians would want to practice medicine if aspirin was not available to them. Although it is not a cure for any known disease, aspirin is helpful in so many conditions, such as fever and pain, that it is not unusual for doctors to tell their patients to take a couple of aspirin for almost anything that is wrong with them. Moreover, since only about one person in a thousand is hypersensitive to it, when a patient says he can't take the little white pill, doctors have the same thing in various colors! It is estimated that Americans alone swallow some sixteen billion aspirin tablets a year.

It has been pointed out that regardless of what you pay for it, aspirin is aspirin. In 1958 an editorial in the *New England Journal of Medicine* stated: "It is exceedingly doubtful if there is any real merit over ordinary aspirin in painkillers that combine aspirin with other ingredients, but as a result of the vast advertising campaign many physicians as well as a majority of the public, are convinced that they are indeed superior."

The King of Drugs

Many eulogies have been paid this lowly tablet, not only by doctors and chemists, but also the laity. Doctors have called it "the miracle drug supreme", "the most useful drug ever found" and "the king of drugs."

In the *Year Book of Drug Therapy* for 1956, the writer of the section on aspirin closed his article by saying "What a drug!"

John Daly, one of television's better known newsmen has said of aspirin: "Without it the news fraternity would long since have distributed itself in about equal numbers among the less expensive sanatoriums, the Foreign Legion and the grave."

One tragic aspect associated with aspirin, however, is its deadly effect in overdose amounts. About seven percent of the 1,500 children who die of accidential poisoning each year are the victims of aspirin. This may be partly because the public fails to recognize aspirin for what it is — a drug. People usually relate drugs to a drugstore. Aspirin can be bought most anywhere without a prescription. It has also been pointed out, however, that with few other drugs is there such a wide margin between a dose that is usually helpful and a dose that is usually harmful.

A recent article in *Newsweek* magazine for April 29 states that researchers from Scripps Clinic and Research Foundation in La Jolla, California, have discovered that the "ability of the acetyl group to combine with body chemicals could help explain why aspirin is a better pain reliever than sodium salicylate." They have also discovered that "aspirin alters serum albumin, the main protein in the blood plasma." They further state that "aspirin seems to 'acetylate' other important substances besides albumin—in the test tube" such as gamma globulin, hormones and DNA, the genetic material. These findings then pose the question: Will aspirin continue to be as *safe* as it is presently regarded?

Thus this "wonder drug" whose usefulness was discovered over 60 years ago and unwillingly ascribed to by the man who became wealthy because of the discovery, has become the most widely used, the cheapest and unless someday proven otherwise, the safest drug in the world. ◄

1668 Christopher Lane
Indianapolis 46224

APPLICATION FOR TERM LIFE INSURANCE
to PROFESSIONAL LIFE & CASUALTY COMPANY, CHICAGO, ILLINOIS

1. Full Name of Applicant_____

Date of Birth_____ Place of Birth_____
Mo. Day Year City State

2. Height_____ Weight_____ 3. ☐ Male, ☐ Female 4. ☐ Married, ☐ Single, ☐ Divorced, ☐ Separated

5. PERMANENT MAILING ADDRESS: _____ (_____)
Street Address
City State Zip No. of Yrs.

6. Medical School: _____
Name City & State

Date Entered Medical School_____

7. AMOUNT OF INSURANCE: 10 YEAR CONVERTIBLE* TERM OR 15 YEAR CONVERTIBLE* TERM

☐ $10,000.00 ☐ $10,000.00
☐ $20,000.00 ☐ $20,000.00

**Convertible to participating Whole Life Insurance at any time priar to the end af the Term period.*

8. PREMIUMS PAYABLE: ☐ Annually ☐ Semi-Annually ☐ Other_____ Premium: $_____

9. DISPOSITION OF ANNUAL DIVIDENDS: ☐ Pay in Cash ☐ Accumulate at Interest ☐ Apply to Premium

10. Beneficiary_____
Name in Full Relationship

11. Do you know of any impairment now existing in your health or physical condition? Yes_____ No_____ If "yes" give particulars_____

12. Have you consulted a physician for illness during the past three years? Yes_____ No_____ If "yes" give particulars_____

I HEREBY APPLY for insurance described above and agree to pay premiums therefor at the rate shown above. INFORMATION in this application is given to obtain this insurance and is true and complete to the best of my knowledge and belief. The Company shall incur no obligation because of this application unless and until it is approved by the Company and the first premium is paid in full while my health or other conditions affecting my insurability are as described in the application.

Date_____ _____
Signature of Applicant

_____
Licensed Agent

Form No. L-168-67A

Fill out and mail to Professional Life & Casualty Co., 720 N. Michigan Ave., Chicago, Ill. 60611

Start your program of insurance protection today, while premiums are low with a Term-Life Plan that meets today's needs with a protective look towards the future.

Professional Life & Casualty Company which has made a career of serving the life and disability insurance needs of members of the medical community introduces its new Guaranteed Convertible Term-Life Plan developed for students, interns and residents who are commencing a career in the medical profession.

This plan is designed for maximum protection with a nominal premium you can afford, prior to your productive earning years.

The low annual premium provides a level amount of life insurance during a period when you may have real need for the financial protection and benefit of your family and dependents or of anyone financing your education.

ANNUAL DIVIDENDS

This is a 'participating plan' which means you participate in annual dividends to policyholders. You may elect to have your Annual Dividends *paid in cash,* applied to reduce your annual premium or accumulated at interest (see item 9 of application).

LOW, FIXED ANNUAL PREMIUM

Your Annual Premium is based on your age at issue (nearest birthday) and remains the same for the duration of the policy. *It cannot be changed by the Company.*

NON-DECREASING COVERAGE

You may select either $10,000 or $20,000 of life insurance. Your insurance will continue for the amount and term you select (10 year or 15 year term period) and *cannot be reduced or terminated by the Company.*

GUARANTEED CONVERSION

Your term policy may be converted to our Participating Whole Life Plan at any time during the policy period *without any restrictions or limitations.*

THE IMPORTANCE OF CONVERSION TO PLC's PARTICIPATING WHOLE LIFE PLAN

Your Term Plan guarantees you the right to obtain PLC's participating Whole Life Plan which has been rated the No. 1 "low net cost" plan by a nationwide statistical service.

The rating was based on comparisons with similar plans issued by the 25 largest U. S. life insurance companies as well as with similar plans issued by the 100 lowest 'net cost' life insurers in the nation.

Pick your own plan and compare! Prove it to yourself that here is a maximum protection plan you need . . . and you can afford.

GUARANTEED CONVERTIBLE TERM INSURANCE
Premiums for $10,000 POLICY

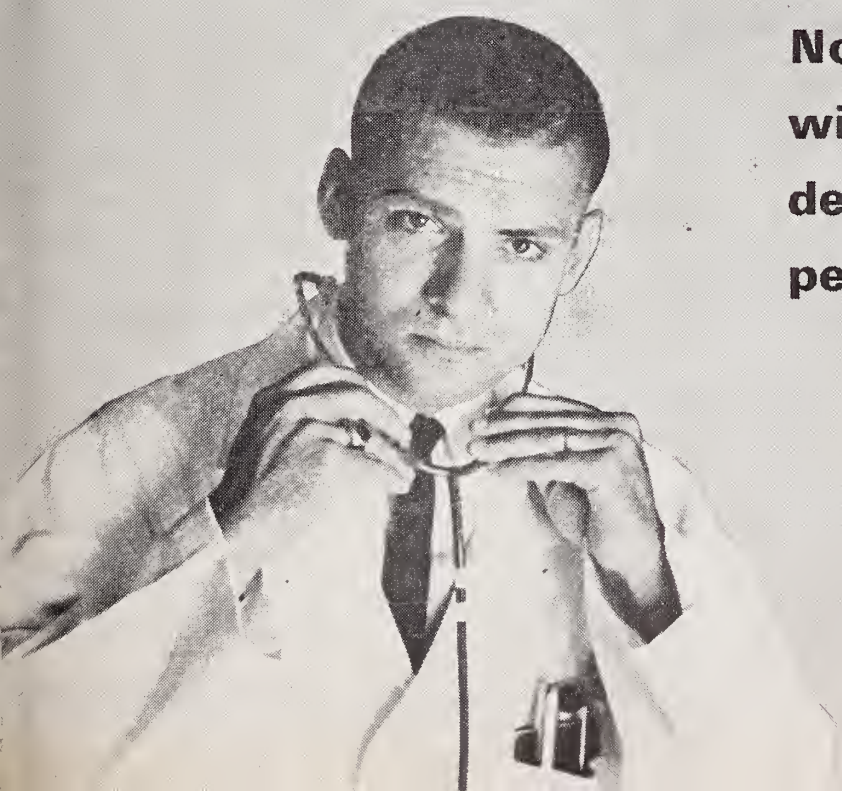
Age At Issue (Nearest Birthday)	10 YEAR TERM Annual	10 YEAR TERM Semi-Annual	15 YEAR TERM Annual	15 YEAR TERM Semi-Annual
21	$33.00	$17.00	$34.00	$17.50
22	33.50	17.50	34.50	18.00
23	34.00	17.50	35.00	18.00
24	34.50	18.00	35.50	18.50
25	35.00	18.00	36.00	18.50
26	35.50	18.50	36.50	19.00
27	36.00	18.50	37.50	19.50
28	36.50	19.00	38.50	20.00
29	37.00	19.50	40.00	21.00
30	37.50	19.50	42.00	22.00

—Premiums for $20,000 Policy are double the above rates
—Premiums for Ages not shown will be provided on request

Professional Life & Casualty Company

HOME OFFICE: 720 N. Michigan Ave., Chicago, Illinois 60611

CHAIRMAN—Edwin S. Hamilton, M.D.
PRESIDENT—Edward L. Compere, M.D.
GENERAL MANAGER & ACTUARY—Norman R. B. King
ASSOC. MED. DIR.—E. Clinton Texter, Jr., M.D.



Now we have a Term-Life Plan with premiums you can afford designed for conversion to permanent life protection.

Local Board of Health Services—Today and Tomorrow

LEE J. MARIS, M.D.
Attica**

ANY Board of Health has continual policy changes as it increases its services due to federal legislation. These changes in the medical practice, as a result of legislation, are a WAY OF LIFE. They are also the means for returning money to the Board of Health and to the county health fund, resulting in the eventual self-support of the Board of Health and giving of services without cost. These points will be a great surprise to some people who are critical of boards of health.

The Board of Health co-operates with the county school consolidations, the TB associations, the welfare departments, the board of commissioners, Head Start programs, divisions of the State Board of Health, nursing homes, county homes, mental health departments, crippled children's associations, medical associations, Indiana Commission on the Aging and the Aged and the Speech and Hearing Department at Purdue. We take care of the township trustee's medically indigent, both adults and children; give cancer care; fracture care; venereal disease care; stroke patient care; care of the disabled and care for the blind.

The $36,700.00 budget is distributed as $29,000.00 in administration and $7,700.00 in operations. This cost is divided between the two counties in proportion to population or approximately 68% to Fountain County and 32% to Warren county.

* Speech made to the Rotary Club of Fountain and Warren Counties.

** Health Officer, Fountain-Warren County Health Department.

Enviornmental Sanitation

The Board of Health Sanitarian exerts control over septic tanks, sanitary disposal systems of sewers and sewage disposal systems. By exerting this control, the health department prevents bacterial contamination and disease. This service calls for the use of color dyes to determine soil penetration. Samples are taken for bacterial counts and harmful chemicals, resulting in complete community sanitation. Municipal and private water supplies are also regularly sampled; private water is tested and professional advice given. Laws that apply to insanitary housing may demand abandonment and condemnation of some homes, resulting in control of the ghetto type of housing in our community.

Environmental sanitation in co-operation with the Town Board, city councils and county commissioners for sewers, land-fills, trash dumps, septic tanks and inspection on housing is done without financial support. We also inspect nursing homes and aid in their licensing in co-operation with the State Board of Health. More of this is to come as to laws change in the very near future.

Lake, Pool Inspections

Technical advice is associated with the inspection of the five swimming pools in the two counties. This is not only for sampling, but includes advice and instruction for proper chlorination and turbidity. The pools must be clear enough to see someone in distress under the water. There is also recreational lake inspection with water sampling. When the Big Pine Reservoir becomes a reality, sanitation conti there will be a necessity. If this not done, a condition similar to th of Lake Manitou will occur, whi would prevent the recreational val of the reservoir. Lake Manitou su fered pollution recently with col bacilli, but this condition has be corrected.

Record Keeping

Records are made, kept and giv out as certified copies of birth, dea and adoption. Amendments to birt and delayed registration of birt are done in co-operation with t State Board of Health. Communi able diseases are recorded and r ports are collected and periodical made to the State Board of Healt The quarantine law is enacted needed.

As you know, the law requir school teachers, bus drivers an janitors to have an examination fo communicable disease, includin chest x-ray, every three years. Scho food handlers and food handlers i restaurants are required to do th yearly. Food handlers in restaurant groceries and ice cream drive-ins ar all required to have yearly Tine Tes and chest x-rays if the Tine Test i positive. The Board of Health keep these records and enforces same All TB case records are kept an isolation checked if the case is active Regular chest x-ray is required; the are also required for two years afte the case is declared inactive.

The Board of Health nurses mad 128 calls for TB in 1967. The law requires all new school entrants t be Tine tested and to have diphtheria tetanus and whooping cough im munizations. Those children medi cally indigent are given three DPT

shots, measles vaccine, polio vaccine and Tine tested for TB. There were about 7,000 children tested by audiometer for hearing and tested for vision including amblyopia tests.

A department of the State Board of Health checks our records and treatments for venereal disease cases and contacts. Our health department also advises as to animal bites and treatment.

Nursing Services

There are two types of nursing services furnished by the Fountain-Warren County Health Department:

1. *Home Visit:* A skilled nursing call in the home is made by county nurses for patients any age not on Medicare.
2. *Home Health Visit:* A skilled nursing call furnished by the Fountain-Warren County Health Department to patients covered by Medicare. The Fountain-Warren County Health Department is the authorized agency through the federal government to make these calls and bill to Medicare through Blue Cross for this service. It is the only agency in the bi-county area doing this service.

There are also nursing home investigations and treatment home visits of venereal disease. There were 120 cardiac-vascular renal calls, 35 cancer calls, and also many home nursing visits made to the county home. There have been 270 such visits up to August 1, 1968. The county home visits save the counties much money. There were 22 home visits for child neglect; these calls are usually requested by the court.

In 1966 and 1967 we had a school problem of head lice and ringworm; 4,995 inspections were done on school children with the Wood's light. There were 3,644 school dental examinations to determine dental fluoride effectiveness. The toothpaste was furnished by the State Board of Health.

There were 83 home calls for mental health patients. Mental health home calls are requested by our mental hospitals and the family doctors who brief our nurses with the patient's history, diagnosis and medication. The object is to do two things—help these persons to better adjust to home life and problems, and to prevent their rehospitalization. This service is of proven value and it would be impossible to estimate the savings to the county and state by not having to rehospitalize these patients.

There were also 19 nursing home calls to administer physical therapy and other medical care to crippled persons as requested by their physicians.

Head Start Programs

This year we are doing the Head Start audio and visual tests and their immunizations. If we expressed some of these services in dollars and cents, we would arrive at a total of $23,489.00. This does not include inspections for ringworm and head lice; dental, visual and audiometric exams or school Tine testing; home visits for crippled children, underprivileged children, cancer, child neglect, mental health and venereal disease. The active TB patients which we are now treating in the home is saving the counties about $67,744.00 per year. The Indiana State Hospital for Chest Diseases at Rockville charges the county $23.20 per patient per day for this care. The actual dollar income for the health department this year will be close to $5,000.00. The estimate for 1969 is $15,000.00 and for 1970, because of new legislation and the rapid increase in the use of the Home Health Care Agency, will be about $50,000.00. I believe this will be the only county self supported group. Our critics won't be able to believe this.

I was called to Indianapolis last fall, again the 30th of April and will go again in October to be briefed on the rapid changes of health situations. Now I am here at the invitation of the Rotary Club, a group of community leaders, to discuss what is developing in medicine and medical legislation and perhaps, because of personal criticism which has been current, related to the board of health. As your health officer and a member of your medical society, I want to make some profound remarks.

Winston Churchill observed that the three most difficult things for a man to do was to climb a wall leaning toward him, to kiss a woman leaning away from him and to make an after dinner speech. Never having been a human fly, I cannot comment on the first of these Herculean feats, I know better than to comment on the second and it has been said that a profound speech is one which leaves the speaker and the audience in utter confusion.

Comprehensive Health Planning

Now to be profound. . . .The federal government has legislated that each state have a Comprehensive Health Planning Group with committees at a local level to suggest and make plans on health that will be passed on to the medical society, local welfare, board of health, churches, hospital boards, nurses associations, dental societies and family planning groups. This State Health Comprehensive Planning Group must communicate and be coordinated with the state and the federal level of medical comprehensive planning. The policy must be uniform throughout federal, state and local levels. The local medical society appointed 25 or 30 representative people in Fountain and Warren counties, to be approved at a state and federal level, for this important action on policy-making in health.

There is also a new Medicaid law which is expected to be accepted by our state legislature, basically because more than $30,000,000.00 in funds from a federal level will be withheld unless the state accepts and co-operates in Comprehensive

Health Planning. The Medicaid law co-ordinates with Medicare and is a part of Social Security. Medicaid will increase our welfare assistance support from a present 53% to 75%. It will benefit destitute children, the retarded and the blind. It will extend licensing of nursing homes and will create three categories of nursing homes.

The present licensed nursing home is called an extended comprehensive care home. The new law will create an intermediate care facility and a home boarding, laundry and housing facility. There will be no limit to the number of home health care calls for those in the two new types of nursing homes and also those below 65 who are completely disabled and are now covered by the said Social Security law, plus the blind and the destitute children, retarded people and court wards.

It is also thought at this time, by state doctors and attorneys, that the local board of health and a social worker from the welfare department will act or function together in a utilization revue of the proper placement of patients in these three categories. This is so they may be shifted from time to time as their needs change. This is a remarkable addition to the Social Security Medicare which is coming and which will certainly affect the local Fountain-Warren County Board of Health, county welfare, county homes and the local government as well as the Social Security beneficiaries. This will result in the transfer of persons in the county homes to one of the new Medicaid Social Security-covered nursing homes. At present the two counties are maintaining the county farms at approximately $47,000.00 per year; Warren county at $29,000.00 and Fountain county at $18,000.00 The counties will not have to appropriate funds and levy tax rates to maintain a county farm.

The Rockville Indiana State Hospital for Chest Diseases will be closed and the people from this area will be seen by a division of the Vigo County Board of Health, disposition will be to a local Terre Haute hospital in isolation, or to the home where local board of health nurses will administer treatment in co operation with the family doctor. We are caring for eight patients now. The Vigo county agency will follow-up these patients. Those few people who have criticized the Fountain-Warren County Board of Health don't understand our Home Health Care Agency within the local board of health and its relationship to the Social Security Medicare and Social Security Medicaid. Now I have explained how the Fountain-Warren County Board of Health will support itself economically and have named its functions. I hope I have been diplomatically helpful and informative. ◀

108 W. Mill St.
Attica 47918

Is It Ethical?

Is it ethically proper to publish studies concerning the health or illness of public figures after their death?

The AMA Judicial Council states that one need not condemn those who, after the death of public figures, discuss their prior medical conditions. However, respect for the dignity of man, respect for the deceased, and respect for the medical profession strongly suggest that only some clear and meaningful benefit would justify such discussion.

VOYAGER 1000

YOUR PLANE IS WAITING

FLY TO BRITISH $65 ROUND TRIP WEST INDIES

The ideal week-end, or week-long getaway for tired, time-pressed physicians.

GO WITH YOUR FRIENDS FOR SHORT, FUN-PACKED TRIPS . . . AT ABOUT ½ THE USUAL COST.

Fly the world for less than 3¢ per mile in Voyager's giant four engine DC-7C and DC-7B aircraft. You too, can join Voyager members . . . meet new friends, find new world's of fun . . . travel luxuriously for less than the cost by bus! No bothersome details. All arrangements made for you.

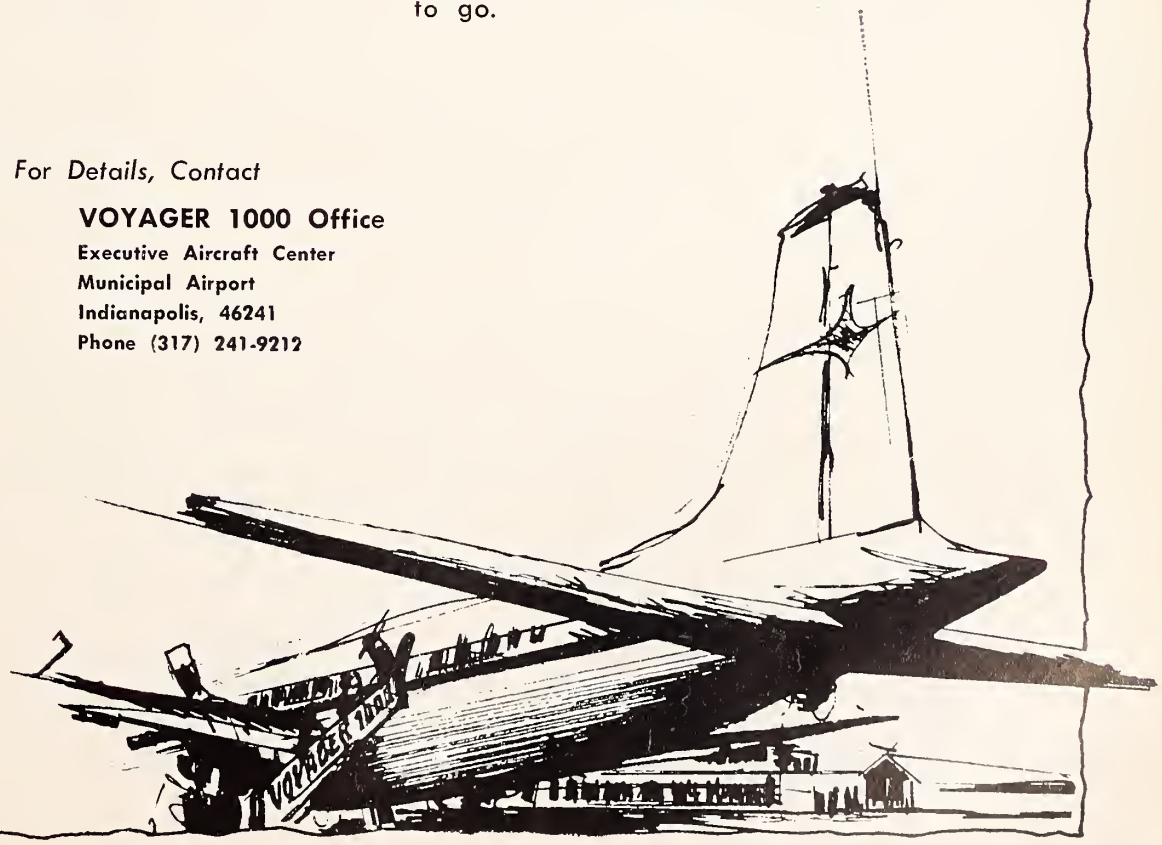
VISIT SUCH DREAM SPOTS AS:

- Montego Bay, Jamaica, $90.00 round trip
- Acapulco, $130.00 round trip
- Grand Bahama Island, $65.00 round trip
- Spain & Portugal, $255.00 round trip
- Los Angeles—San Diego, $120.00 round trip
- Quebec, $55.00 round trip (Children $37.50)

Or how about New York, Las Vegas, Paris, Rome, Zurich, Africa, or Hong Kong . . . see the Taj Mahal. Voyager will be there! Climb aboard the Voyager at our own Terminal. It's the most modern piston airliner ever built . . . fully equipped and manned according to FAA regulations. Voyager 1000 is a club. Now accepting new memberships. Come join the world's most successful flying country club. We fly where and when our members want to go.

For Details, Contact

VOYAGER 1000 Office
Executive Aircraft Center
Municipal Airport
Indianapolis, 46241
Phone (317) 241-9212



The Physician and the National Library of Medicine*

LEONARD KAREL, Ph.D.
Bethesda, Maryland**

WHEN the National Library of Medicine was established in 1836 as the Library of the Surgeon General's Office (U.S. Army), the Surgeon General was authorized to spend $150 for medical literature. Today the library, located at Bethesda, Maryland, near Washington, in a five-story contemporary building which it has occupied since 1962, is regarded as the world's largest in biomedicine. Among its holdings of 1,300,000 items in 70 languages are 315,000 monographs; 310,000 bound journal volumes; 285,000 theses; 168,000 pamphlets; and 4,500 reels of microfilm.

The library provides 175,000 interlibrary loans annually, and of these, 160,000 are photocopies of journal articles not available at the requesting local library. Reference personnel answer 10,000 personal inquiries, 10,000 phone inquiries and 2,000 mail inquiries each year. Requests for 100,000 library items are made by 25,000 to 30,000 persons who use the reading room each year.

The library is a major publisher of biomedical bibliographies; e.g., *Index Medicus*, *Cumulated Index Medicus*, *Bibliography of Medical Reviews*, *Biomedical Serials* 1950 - 1960, *Bibliography of the History of Medicine;* and *NLM Current Catalog*. Among other library publications are *Medical Subject Headings*, the thesaurus for *Index Medicus; List of Journals Indexed in Medicus; National Library of Medicine Classification;* and *Russian Drug Index.*

Renamed in 1922, 1952, 1956

Known for 86 years as the Library of the Surgeon General's Office, the library was developed as both a national and an international resource by Dr. John Shaw Billings, librarian from 1865 to 1895. In 1922, it was renamed the Army Medical Library and in 1952 was again renamed the Armed Forces Medical Library. In 1956, under legislation introduced by Senators Lister Hill of Alabama and John F. Kennedy of Massachusetts, it was transferred to the Public Health Service, Department of Health, Education and Welfare, and named the National Library of Medicine.

The library was established by the Congress of the United States to assist in the advancement of medical and medically related sciences by the collection, dissemination and exchange of scientific and other information important to the progress of medicine and of public health.

Towards fulfillment of its mission, the library (1) acquires and preserves books, periodicals, films, prints and other library materials pertinent to medicine; (2) organizes these materials by appropriate cataloging, indexing and bibliographic listings; (3) publishes and disseminates catalogues, indexes, and bibliographies; (4) distributes materials through interlibrary loans, photographic or other copying procedures; (5) provides reference and research assistance; and (6) encourages, promotes and supports activities to further the progress of medicine and of public health by strengthening existing services and developing new ones.

The Congressional mandate was strengthened recently when, on October 22, 1965, President Johnson signed the Medical Library Assistance Act, Public Law 89-291 of the 89th Congress. In signing the act, the President commented that the nation's medical libraries are a vital link between medical education, practice, and research, and that too little attention has been given to the problem of collecting and sharing scientific knowledge.

The Medical Library Assistance Act is an amendment to the legislation authorizing the establishment of the library. The act permits assistance to medical libraries for construction and renovation, for acquisition and for improvement of resources, for training of medical librarians and other information specialists, for preparation of publications, for research in medical library science and for the development of regional medical libraries. The act also authorizes traineeships, fellowships and special scientific projects by individuals or institutions.

Administration of the act on behalf of the library is done by the library's Extramural Programs.

The library today serves as the principal national focus of resources and programs for bettering communication in medicine and the health sciences and is encouraging the development of the existing system of medical libraries into a national medical information network. On July 1, 1967, the library acquired the Public Health Service Audio-

* Originally published in *Pennsylvania Medicine* and revised in part for publication in *The Journal of the Indiana State Medical Association* and other state journals through an agreement among members of the State Medical Journal Advertising Bureau.

** Special Assistant to the Associate Director for Intramural Programs, National Library of Medicine, Bethesda 20014.

visual Facility in Atlanta, Georgia. This facility was renamed the National Medical Audiovisual Center and will coordinate a national program in biomedical audiovisuals.

Access to the collection is facilitated through an interlibrary loan program. When libraries request loans through medical library channels, the National Library of Medicine lends books within the United States and, worldwide, provides single copies of articles from journals which the requesting libraries do not possess and which are not available locally. There is no charge for this service or for other services except special photography.

The library collects materials comprehensively in some 40 biomedical subject categories and selectively in many related categories. The collection, in which are over 19,000 serial titles, is increased annually by 95,000-100,000 items. It is estimated that the library now stores 369 million pages, of which 85 million are pre-1870, and that at least 10 million more are being acquired annually.

Its History of Medicine Division alone has between 60,000 and 65,000 printed works bearing publication dates earlier than 1801. Included in the collection are: an Arabic manuscript of the year 1094 on gastrointestinal disease; a collection of palm-leaf manuscripts from Ceylon, in Singhalese; works of Hippocrates and Galen; and letters written by George Washington, by Benjamin Rush and by Florence Nightingale. Holdings also include 535 incunabula; 33,000 16th, 17th, and 18th century monographs; 1,600 17th century theses and pamphlets; 2,000 early American medical works; and an estimated 60,000 prints and photographs.

Computerized Library Services

Efforts of conscientious, busy practitioners to achieve and to maintain awareness of most recent medical discoveries and applications have often led to many and continuing frustrations. The increase in the volume of medical literature and in the number of users has not been paralleled by equivalent growth of medical libraries and of information storage and retrieval methods and facilities adequate to catalogue, index, store, and retrieve literature for use of physicians, scientists, and others. Therefore, the library adopted computerization as a means of assisting, supplementing, and complementing traditional approaches to management of published biomedical literature and pioneered in the use of computers for storage and retrieval of bibliographic information.

In January 1964, a computer-based information storage and retrieval system called MEDLARS (Medical Literature Analysis and Retrieval System) became operational at the library.

MEDLARS joins the professional experience of trained literature analysts and searchers with the processing capabilities of a high-speed electronic computer. The literature analysts, using terms selected from a thesaurus of approximately 7,000 terms, *Medical Subject Headings* (Part II of the January issue of *Index Medicus*), characterize each article by assigning to it a number of subject headings or descriptors. Indexed articles are entered into the computer and transferred to magnetic tapes for storage, and for rapid retrieval. Currently, MEDLARS contains over 550,000 citations to biomedical journal articles published since January, 1964. About 55% of these are in English.

MEDLARS has improved the quality of the library's monthly *Index Medicus* and has substantially reduced the time required for the production of other library bibliographies.

Index Medicus, a comprehensive, monthly subject-author index, now incorporates 180,000 articles annually from nearly 2,300 of the world's biomedical journals. At the close of each calendar year, MEDLARS compiles *Cumulated Index Medicus*, a complete listing, with cross-references, of the citations which were printed in that year's issues of *Index Medicus*. An abridged edition of *Index Medicus* for the personal use of physicians is being planned in cooperation with the American Medical Association.

(MEDLARS does not now include monographs, symposia, conferences, congresses, and proceedings not published in journals.)

The journals indexed in *Index Medicus* (approximately 2,300) are selected with the advice of an extramural committee whose decisions are made largely on the quality of the journal under consideration; however, care is taken to assure subject balance. Discussions of journals are based on prior knowledge of the journal and on inspection of the journal by committee representatives. In addition, the committee is assisted by advice from subject specialists. Comprising the present committee are physicians and scientists, medical editors, and medical librarians.

MEDLARS makes possible rapid machine searches of biomedical journal literature to obtain answers to reference questions that cannot be handled expeditiously by manual searches. Machine searches which provide citations to medical literature in specific areas of interest are called "demand bibliographies."

MEDLARS is responding to more than 400 highly specific computer search requests monthly. These requests are coming chiefly from physicians, teachers, and researchers in medical schools, hospitals, universities, and Federal research laboratories.

In addition to demand bibliographies, the library collaborates with professional societies and other professional organizations in the preparation of "recurring bibliographies"—formally published.

The Physician and the National Library of Medicine*

LEONARD KAREL, Ph.D.
Bethesda, Maryland**

WHEN the National Library of Medicine was established in 1836 as the Library of the Surgeon General's Office (U.S. Army), the Surgeon General was authorized to spend $150 for medical literature. Today the library, located at Bethesda, Maryland, near Washington, in a five-story contemporary building which it has occupied since 1962, is regarded as the world's largest in biomedicine. Among its holdings of 1,300,000 items in 70 languages are 315,000 monographs; 310,000 bound journal volumes; 285,000 theses; 168,000 pamphlets; and 4,500 reels of microfilm.

The library provides 175,000 interlibrary loans annually, and of these, 160,000 are photocopies of journal articles not available at the requesting local library. Reference personnel answer 10,000 personal inquiries, 10,000 phone inquiries and 2,000 mail inquiries each year. Requests for 100,000 library items are made by 25,000 to 30,000 persons who use the reading room each year.

The library is a major publisher of biomedical bibliographies; e.g., *Index Medicus, Cumulated Index Medicus, Bibliography of Medical Reviews, Biomedical Serials* 1950 - 1960, *Bibliography of the History of Medicine;* and *NLM Current Catalog.* Among other library publications are *Medical Subject Headings*, the thesaurus for *Index Medicus; List of Journals Indexed in Medicus; National Library of Medicine Classification;* and *Russian Drug Index.*

Renamed in 1922, 1952, 1956

Known for 86 years as the Library of the Surgeon General's Office, the library was developed as both a national and an international resource by Dr. John Shaw Billings, librarian from 1865 to 1895. In 1922, it was renamed the Army Medical Library and in 1952 was again renamed the Armed Forces Medical Library. In 1956, under legislation introduced by Senators Lister Hill of Alabama and John F. Kennedy of Massachusetts, it was transferred to the Public Health Service, Department of Health, Education and Welfare, and named the National Library of Medicine.

The library was established by the Congress of the United States to assist in the advancement of medical and medically related sciences by the collection, dissemination and exchange of scientific and other information important to the progress of medicine and of public health.

Towards fulfillment of its mission, the library (1) acquires and preserves books, periodicals, films, prints and other library materials pertinent to medicine; (2) organizes these materials by appropriate cataloging, indexing and bibliographic listings; (3) publishes and disseminates catalogues, indexes, and bibliographies; (4) distributes materials through interlibrary loans, photographic or other copying procedures; (5) provides reference and research assistance; and (6) encourages, promotes and supports activities to further the progress of medicine and of public health by strengthening existing services and developing new ones.

The Congressional mandate was strengthened recently when, on October 22, 1965, President Johnson signed the Medical Library Assistance Act, Public Law 89-291 of the 89th Congress. In signing the act, the President commented that the nation's medical libraries are a vital link between medical education, practice, and research, and that too little attention has been given to the problem of collecting and sharing scientific knowledge.

The Medical Library Assistance Act is an amendment to the legislation authorizing the establishment of the library. The act permits assistance to medical libraries for construction and renovation, for acquisition and for improvement of resources, for training of medical librarians and other information specialists, for preparation of publications, for research in medical library science and for the development of regional medical libraries. The act also authorizes traineeships, fellowships and special scientific projects by individuals or institutions.

Administration of the act on behalf of the library is done by the library's Extramural Programs.

The library today serves as the principal national focus of resources and programs for bettering communication in medicine and the health sciences and is encouraging the development of the existing system of medical libraries into a national medical information network. On July 1, 1967, the library acquired the Public Health Service Audio-

* Originally published in *Pennsylvania Medicine* and revised in part for publication in *The Journal of the Indiana State Medical Association* and other state journals through an agreement among members of the State Medical Journal Advertising Bureau.

** Special Assistant to the Associate Director for Intramural Programs, National Library of Medicine, Bethesda 20014.

visual Facility in Atlanta, Georgia. This facility was renamed the National Medical Audiovisual Center and will coordinate a national program in biomedical audiovisuals.

Access to the collection is facilitated through an interlibrary loan program. When libraries request loans through medical library channels, the National Library of Medicine lends books within the United States and, worldwide, provides single copies of articles from journals which the requesting libraries do not possess and which are not available locally. There is no charge for this service or for other services except special photography.

The library collects materials comprehensively in some 40 biomedical subject categories and selectively in many related categories. The collection, in which are over 19,000 serial titles, is increased annually by 95,000-100,000 items. It is estimated that the library now stores 360 million pages, of which 85 million are pre-1870, and that at least 10 million more are being acquired annually.

Its History of Medicine Division alone has between 60,000 and 65,000 printed works bearing publication dates earlier than 1801. Included in the collection are: an Arabic manuscript of the year 1094 on gastrointestinal disease; a collection of palm-leaf manuscripts from Ceylon, in Singhalese; works of Hippocrates and Galen; and letters written by George Washington, by Benjamin Rush and by Florence Nightingale. Holdings also include 535 incunabula; 33,000 16th, 17th, and 18th century monographs; 1,600 17th century theses and pamphlets; 2,000 early American medical works; and an estimated 60,000 prints and photographs.

Computerized Library Services

Efforts of conscientious, busy practitioners to achieve and to maintain awareness of most recent medical discoveries and applications have often led to many and continuing frustrations. The increase in the volume of medical literature and in the number of users has not been paralleled by equivalent growth of medical libraries and of information storage and retrieval methods and facilities adequate to catalogue, index, store, and retrieve literature for use of physicians, scientists, and others. Therefore, the library adopted computerization as a means of assisting, supplementing, and complementing traditional approaches to management of published biomedical literature and pioneered in the use of computers for storage and retrieval of bibliographic information.

In January 1964, a computer-based information storage and retrieval system called MEDLARS (Medical Literature Analysis and Retrieval System) became operational at the library.

MEDLARS joins the professional experience of trained literature analysts and searchers with the processing capabilities of a high-speed electronic computer. The literature analysts, using terms selected from a thesaurus of approximately 7,000 terms, *Medical Subject Headings* (Part II of the January issue of *Index Medicus*), characterize each article by assigning to it a number of subject headings or descriptors. Indexed articles are entered into the computer and transferred to magnetic tapes for storage, and for rapid retrieval. Currently, MEDLARS contains over 550,000 citations to biomedical journal articles published since January, 1964. About 55% of these are in English.

MEDLARS has improved the quality of the library's monthly *Index Medicus* and has substantially reduced the time required for the production of other library bibliographies.

Index Medicus, a comprehensive, monthly subject-author index, now incorporates 180,000 articles annually from nearly 2,300 of the world's biomedical journals. At the close of each calendar year, MEDLARS compiles *Cumulated Index Medicus*, a complete listing, with cross-references, of the citations which were printed in that year's issues of *Index Medicus*. An abridged edition of *Index Medicus* for the personal use of physicians is being planned in cooperation with the American Medical Association.

(MEDLARS does not now include monographs, symposia, conferences, congresses, and proceedings not published in journals.)

The journals indexed in *Index Medicus* (approximately 2,300) are selected with the advice of an extramural committee whose decisions are made largely on the quality of the journal under consideration; however, care is taken to assure subject balance. Discussions of journals are based on prior knowledge of the journal and on inspection of the journal by committee representatives. In addition, the committee is assisted by advice from subject specialists. Comprising the present committee are physicians and scientists, medical editors, and medical librarians.

MEDLARS makes possible rapid machine searches of biomedical journal literature to obtain answers to reference questions that cannot be handled expeditiously by manual searches. Machine searches which provide citations to medical literature in specific areas of interest are called "demand bibliographies."

MEDLARS is responding to more than 400 highly specific computer search requests monthly. These requests are coming chiefly from physicians, teachers, and researchers in medical schools, hospitals, universities, and Federal research laboratories.

In addition to demand bibliographies, the library collaborates with professional societies and other professional organizations in the preparation of "recurring bibliographies"—formally published.

widely distributed bibliographies in specialized areas of broad interest.

These recurring bibliographies are *Artificial Kidney Bibliography; Bibliography of Medical Education; Cerebrovascular Bibliography; Fibrinolysis, Thrombolysis, and Blood Clotting; Index of Rheumatology; Index to Dental Literature;* and *International Nursing Index.*

Although the library supplies the sponsoring organization with citations retrieved periodically from MEDLARS on film ready for offset printing, publishing and distributing the bibliography—on a nonprofit basis—is the responsibility of the sponsoring organization.

At frequent intervals, generally monthly, the library selects from its demand bibliographies a few considered to be a general interest. Announcements of the availability of these bibliographies, called *NLM Literature Searches,* appear in the *Journal of the American Medical Association, Public Health Reports, Journal of the American Dental Association, NLM News,* and other publications including state journals. There is no charge for these searches. Clinicians, educators, and researchers interested in receiving notices on new *NLM Literature Searches* may write to the Office of Assistant to the Director, National Library of Medicine, 8600 Rockville Pike, Bethesda, Maryland 20014.

To enhance effectiveness of MEDLARS, the library has provided its computer tapes and programs to university-affiliated centers which can make computer-generated demand bibliographies available locally or regionally to qualified practitioners, educators, and researchers. Decentralized MEDLARS stations are now in operation or will soon be in operation at Harvard University, the University of Alabama, the University of California at Los Angeles, the University of Colorado, and the University of Michigan. Others are being considered, and as regional libraries, authorized by the Medical Library Assistance Act, are identified, they, too, will be provided with a MEDLARS search capability.

Two MEDLARS centers are in operation outside the United States: In the United Kingdom under a cooperative arrangement between the University of Newcastle-upon-Tyne and the National Lending Library for Science and Technology at Boston Spa, Yorkshire, demand bibliographies are provided by the Lending Library. In Sweden, literature references taken from MEDLARS tapes are being provided by the Karolinska Institute in Stockholm.

Physicians wishing to obtain demand bibliographies are encouraged to seek the advice of local medical librarians on suitability of the inquiries and on the preparation of requests which will elicit the information sought. The use of *Medical Subject Headings, Guide to MEDLARS Services,* and an expression of specific interests will help avoid retrieval of irrelevant citations. Thus, a request specifying animal experiments will help to insure that citations on human studies will not appear in the bibliography; similarly, specifying a single age group will obviate retrieval on all age groups.

Citations may be arranged alphabetically by senior author, by journal title, by language, by subject headings, and by year of publication, and each citation can be printed with the descriptors assigned to it by its indexer. Although the computer can print bibliographies on 8½ x 11 paper or on 3 x 5 cards, usually the printout is provided on the less costly paper.

The elapsed time between receipt of a request and mailing of a bibliography is a function of the volume of searches requested. At present, elapsed time is about three weeks.

It is important to note that MEDLARS does not produce abstracts. It is also important to note that MEDLARS services are not provided for searches which can be conveniently and readily accomplished by the use of published indexes, handbooks, and other reference materials.

Requests From Indiana

During the period July, 1966—June, 1967, inclusive, the National Library of Medicine responded to 33 demand bibliography requests from biomedical personnel in the state of Indiana.

Subjects ranged from intestinal carbohydrate dyspepsia and carbohydrate metabolism in malabsorption syndrome to uveitis caused by microwave radiation.

The distribution of the 33 requests was:

Indiana University	17
Purdue University	2
University of Notre Dame	1
Federal agencies	1
Other (chiefly physicians)	12
Total	33

Summary

The National Library of Medicine, now the world's largest biomedical library, was established by Congress to further the advancement of medical and medically related

sciences by the collection, dissemination, and exchange of scientific and other information important to the progress of medicine and of public health. It has become an international as well as a national resource for publications and other items relevant to medical communication, and renders service on a worldwide basis.

In January, 1964, a computer-oriented information storage and retrieval system called MEDLARS (Medical Literature Analysis and Retrieval System) became operational at the library. This system has improved the quality of *Index Medicus* and other library-associated publications and has substantially reduced the time required for preparation and publication of such publications.

The MEDLARS store of biomedical journal articles published since January, 1964, now exceeds 550,000 and is growing at an annual rate of 180,000 articles, taken from nearly 2,300 journals. Requests for computer searches come chiefly from physicians, teachers, and scientists in medical schools, hospitals, universities, and federal research laboratories.

During the period July, 1966—June, 1967 inclusive, the National Library of Medicine responded to 33 demand bibliography requests from biomedical personnel in Indiana.

Editor's Note

Indiana physicians wishing to use the services of the National Library of Medicine may request them from the Indiana University School of Medicine Library via the statewide teletype network. The School of Medicine Library will transmit such requests to NLM gratis. ◄

Medical Panorama

A Separate Department of Health?

A. W. CAVINS, M.D.
Terre Haute

THERE is always reluctance among bureaucrats to relinquish any part of their sphere of influence. This apparently goes on today in the Department of Health, Education and Welfare, as it seems difficult for proponents of a separate Department of Health to make much progress. An interesting editorial on this matter appeared in *The Massachusetts Physician* for April, 1968, and is quoted, in part, as follows:

"On November 21, 1967, the Congress passed HR 6418 which extends for two years the Comprehensive Health Planning and Public Health Service Amendment of 1966.

"Unfortunately, an important amendment to this bill, which would have elevated the Undersecretary of Health, Education and Welfare to Deputy Secretary and created an Undersecretary of Health, was deleted from the final version of the bill. The fact that this amendment had been added to the bill is important in that it suggests there is some thinking in the Congress that health per se is a facet of our society important enough to warrant greater recognition. It could have been a valuable step in the creation of an independent Department of Health.

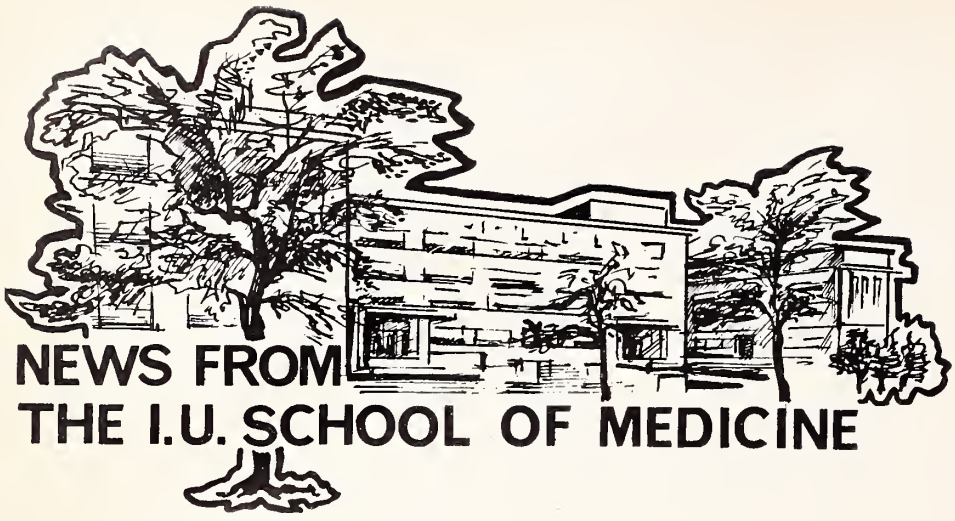
* * *

"The health 'industry' is now one of the truly major concerns of government. The federal government is involved in medical research, medical education and training; through such agencies as Medicare, Medicaid and the Regional Medical Program it has a direct concern in the actual practice of medicine. The United States has embarked on a course in which the federal government will have an increasing role and responsibility in all aspects of medicine. Once embarked on this course, there does not appear much likelihood that it will change its direction significantly.

"In view of this great increase in involvement in medicine by the federal government, the establishment of a separate Department of Health with an officer of cabinet rank in charge seems fully warranted. In spite of the adverse action on the amendment to HR 6418, there is apparently considerable feeling in the Congress in favor of more autonomy and an improved status for health affairs. The support of the entire medical, dental, nursing and other allied health professions is needed if a Department of Health is to be established at an early date."

Of course, Medicare is financed through Social Security, so that formation of a Department of Health may present a problem on that account. Our advice in this respect when Medicare was in the embryonic stage was not heeded at Congressional hearings (testimony by the AMA) but perhaps some lessons have been learned since then. We can hope. ◄

221 S. Sixth St.
Terre Haute 47801



NEWS FROM THE I.U. SCHOOL OF MEDICINE

Dr. William Hugh Headlee, Professor of Parasitic Diseases at the Indiana University School of Medicine and Graduate School, has been named Associate Director of the Division of Allied Health Sciences at the School of Medicine.

He joins Dr. J. Lynn Arbogast, Director of the Division since 1963.

Dr. Headlee, who has been a member of the medical school faculty since 1943, was co-ordinator of the Postgraduate Medical Center project, developed by the I.U. School of Medicine in Pakistan through a contract with the U.S. Agency for International Development, from 1957 to 1966. He has had extensive experience as administrator, teacher and field worker in foreign countries, particularly Egypt, Venezuela and Thailand.

A native of Shelby County, Dr. Headlee received the A.B. degree from Earlham College, Richmond, Ind.; the M.S. from the University of Illinois, and the Ph.D. from Tulane University of Louisiana. He was a Rockefeller Foundation Fellow at Illinois and Tulane. He was a Markle Foundation Fellow for studies on tropical diseases at Walter Reed Army Medical School and in Central America. He is a member of many professional and honorary societies, and he is the author of 42 published papers.

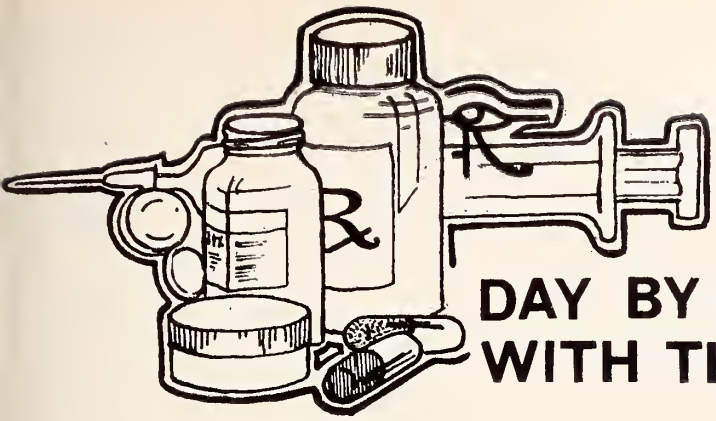
In the Division of Allied Health Sciences, Dr. Headlee will bring his administrative experience to a rapidly expanding facet of medical education. The 12 programs in the division provide vital personnel for the health team. Length of the programs varies from two years of post high school work to four years of college plus an extra summer.

The rapid development of medicine and the great need for associated assistants has resulted in openings for many additional workers in a variety of areas. In order to fill this need, Indiana University is providing many of the courses necessary for degrees in the Division of Allied Health Sciences at its six regional campuses, and in some cases the entire degree program may be completed on a regional campus. The Indianapolis office, through the various regional counsellors, keeps in contact with regional campus students enrolled in the Allied Health Sciences programs. Close contact also is maintained with those students following the prescribed courses on the Bloomington campus.

Allied Health Sciences presently offered by the Division include four in the field of Public Health. These courses and their requirements are *Public Health Dental Hygiene,* one year of undergraduate work, two years at the School of Dentistry, and one year in the Division of Allied Health Sciences at the medical center; *Public Health Education,* three years of undergraduate work and one year at the medical center; *Public Health-Environmental Health* (Sanitation), three years of undergraduate work and one year at the medical center; *Public Health Administration,* three years of undergraduate education in business and one year at the medical center. These all lead to a bachelor of sciences degree granted through the school of medicine.

Other B.S. degree programs in the division are *Medical Technology* which takes three years of undergraduate work and a calendar year at the medical center or an allied hospital; *Medical Records,* three years of undergraduate work and one year at the medical center; *Physical Therapy,* two years of undergraduate work and two years and a summer at the medical center; *Occupational Therapy,* two years of undergraduate work, two years at the medical center and a summer of internship; *Gytotechnology,* three and one-half years at the Bloomington campus and six months at the medical center (by selection only).

Two-year programs include *Inhalation Therapy,* which actually takes one year of undergraduate work and a summer and another year at the medical center and leads to the Associate in Inhalation Therapy Certificate; *Radiologic Technology,* which requires two years at the medical center or at Indiana University at Fort Wayne and leads to the Associate in Science Degree, and *Hospital Dietary Technology,* two years at the medical center for the Associate in Science Degree. The last two degrees are given by the I.U. Division of General and Technical Studies. ◄



DAY BY DAY WITH THE F.D.A.

"Incredible Edibles" and "Gobblydegook" novelty items are manufactured in California. They are intended for use by children and contain sorbitol, glycerine, vegetable gums and starches, but no sugar. They were originally labeled as "sugarless", but are now relabeled to warn against use by diabetics.

* * *

Pseudomonas aeruginosa is an unwelcome and too frequent visitor to hospitals. As though the natural means of entry were not enough, several lots of hospital lotion were found to be contaminated with the organism, apparently by way of contaminated well water. The manufacturer voluntarily recalled all faulty products.

* * *

The Chinese noodle industry was accorded special attention in New York. A sanitation workshop was held for noodle workers. Eggs are the ingredient which require careful sanitary handling.

* * *

A chemical firm in Pennsylvania which distributes fireworks kits and chemicals for home chemistry sets was investigated because of complaints of misbranding of chemicals. Result: Two Temple University students who operate the firm were arrested for making and selling LSD and for selling the ingredients for LSD.

A "Hubbard Mark V E. Meter" imported from England was seized at Miami. It was claimed by the FDA that it was misbranded because of its intended use in diagnosis, treatment and prevention of disease. The label on the device announced that "E. Meter is not intended or effective for the diagnosis, treatment, or prevention of any disease."

* * *

Eight hundred and four tubes of bacitracin ointment made by McKesson & Robbins were seized because of subpotency. The firm's analysts planned to visit the Division of Antibiotics and Insulin Certification to discuss the FDA method of analysis for this product.

* * *

Oxygen respirators, during transport, became contaminated with the pesticide thiodan when the dust entered the uncovered ends of tubes on the respirators.

* * *

30,000 crates of Chilean melons aboard the S.S. Imperial became contaminated with DDT and sodium nitrate which was also carried on the ship. The melons were released after being washed.

* * *

"Ionic Calcium", valued at $2,677, was seized due to misbranding. Labeling suggested that the drug was adequate and effective to cause weight gain; to increase stamina; and to treat colds, destructive diseases of the joints, minor infections, allergic conditions and asthma, among other ills.

* * *

Mung beans, imported from Peru, were detained due to contamination with endrin. The finding was substantiated by a commercial laboratory. When the lab bean grew sprouts, the sprouts were found to contain endrin. The beans are the type used to grow Chinese bean sprouts.

* * *

A repacking firm in New Jersey was found to be repacking glycerin, petrolatum and mineral oil with the same equipment used to manufacture agricultural poisons. Samples of the drugs collected were found to contain malathion, lindane and DDT. The drug products were all intended for shipment to the VA for use in its medical facilities. The firm was ordered to cease work on drugs until it could comply with good manufacturing practices.

* * *

A Japanese novelty item called "Mysterious Myst-All" consists of a dumbbell-shaped glass container, filled with liquid. It is a gag item allegedly able to determine executive power potential. It was ruled as flammable and toxic when the liquid was found to be methanol and 48,000 of them were recalled from national distribution.

* * *

A new "Single System Concept" compliance program is being formed between food and drug agencies of FDA and the states of New York and New Jersey. Officials will be assigned to joint projects instead of duplicating efforts. The case of the New Jersey firm which was inadvertently mixing drugs and agricultural poisons was the first action by the team concept. ◄

GLEANED FROM THE BRITISH MEDICAL JOURNAL

JACK W. HICKMAN, M.D.
Indianapolis

Antibiotic Prevention of Pneumonitis May Be Possible

An article by Collins, Darke and Knowelden stresses once again the importance of anticipation and prevention of respiratory complications that may follow abdominal surgery.[1] Their report covers 132 male patients who had upper abdominal surgery. Roughly one-fourth of the patients experienced at least moderate respiratory complications in the postoperative period. The authors emphasize the importance of identifying the high risk group preoperatively. In this category, they place older patients, those with a history of wheezing or productive morning cough and those demonstrating impaired ventilatory function. Their study, despite others to the contrary, demonstrated that prophylactic treatment with penicillin and streptomycin from the day before surgery through the first five postoperative days reduced the incidence of pulmonary complications by 50%. This study, which appears to be well done, should prompt other reports to see if their findings can be confirmed.

Emotional Side Effects of Hemodialysis are General

An often overlooked aspect of chronic hemodialysis therapy is presented by Menzies and Stewart,[2] when they discuss the psychiatric disturbances that occurred in seven patients who were observed in a nine month period. All seven patients demonstrated quite clear cut, although varying, psychiatric disturbances as their hemodialysis course progressed. None became frankly psychotic, but the psychiatric pictures that developed were a cause of further disability in each case. The emotionally charged atmosphere also took its toll on relatives of the patients and on the nursing personnel involved in the unit. Members of both these groups varied in their emotional responses, but some degree of impairment was seen by the authors. Improved new advances in medical care only serve to illustrate further the need for assessing the patient as a whole being and the importance of considering the patient's family.

Lung Cancer, Bronchitis and Smoking not Settled Yet

Further information about smoking habits and lung cancer is presented by Remington,[3] but it does not go hand in hand with the U. S. Surgeon General's report of a few years ago. The author presents his data concerning smoking habits, sputum production and lung cancer on over 21,000 male volunteers. In this study, which was prospective in nature, it was found that it was the smokers who had a productive cough who had the greatly increased incidence of lung cancer. This greatly increased incidence of lung cancer was not found in smokers who were cough free. The author believes that chronic bronchitis rather than smoking per se is the major area to attack in lung cancer prevention. He suggests that these are the main people to whom anti-smoking propaganda, frequent chest x-rays, etc. should be directed.

REFERENCES

1. Collins, C. D., Darke, C. S., Knowelden, J.: Chest Complications after Upper Abdominal Surgery: Their Anticipation and Prevention, *Brit. Med. J.* 1:401-406, No. 5589.
2. Menzies, I. C., Stewart, W. K.: Psychiatric Observations on Patients Receiving Regular Dialysis Treatment, *Brit. Med. J.* 1:544-547, No. 5591.
3. Remington, J.: Smoking, Sputum, and Lung Cancer, *Brit. Med. J.* 1:732-734, No. 5594. ◄

More Protection For Blue Shield Members

(One of a series prepared by Blue Shield)

Year after year our sales efforts continue to stress the importance of adequate Blue Shield protection. Emphasis is placed on selling the preferred and special surgical programs, preferred and special in-hospital medical protection, diagnostic and pathology endorsements, as well as major medical and local county programs. Every effort is made to sell new accounts—and convert old accounts—to broader benefits.

The table below graphically indicates the success of this sales effort during the five-year period from 1962 to 1967. The number of members protected by each program in each of the two years is indicated.

	1962	1967
Preferred and special surgical	$773,392	$1,365,739
Preferred and special in-hospital medical	669,481	1,241,500
Diagnostic x-ray and pathological services	634,935	1,383,000
Local county programs	None	669,132
Major medical programs	None	422,111
Medicare supplement (direct pay)	None	179,723
The two entries below indicate the effect this sales effort has had in reducing the number of persons who still have the weaker standard programs.		
Standard surgical	696,278	220,920
Standard in-hospital medical	687,998	212,100

W. C. Huddlestone
Public Relations Division

WANTED: Physicians Locations

GENERAL PRACTICE

Arthur Albert Tesi, 5524 Roch Dr., Columbus, Ohio 44224

SPECIALISTS

Ernest Charles Andrews, 1202 Viewridge, San Antonio, Texas 78213—*General Surgery*

M. Adnan Barazi, 2236 N. Karlov, Chicago, Ill. 60639—*General Surgery*

Theodore H. Chuang, 462 Utopia, Apt. 232, San Antonio, Texas 78223—*General Surgery*

Gregorio R. de los Santos, 2200 Richmond Road, Apt. 101, Lexington, Ky.—*General Surgery*

Francisco M. Pagsisihan, 2535 Park Ave. Pasay City, Phillippines—*General Surgery*

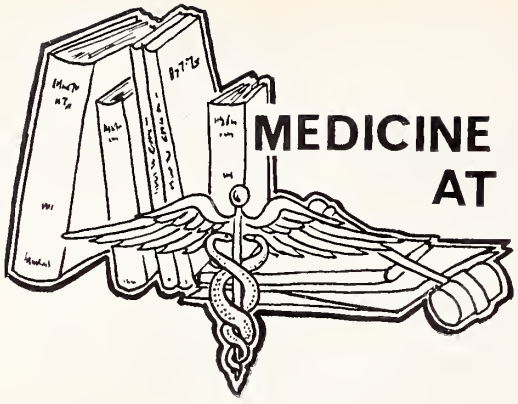
Ray A. Dieter, Jr., Box 88, Hines, Ill. 60141—*Surgery*

Fredric Robert Kutner, 224 C. Gray Plaza, Scott Air Force Base, Ill.—*Surgery*

Anthony M. Tanno, 1464 E. Queen St., Annville, Penn. 17003—*Internal Medicine*

David V. Yana, 11308 Joffre St., Los Angeles, Calif. 90049—*Pathology*

Wesley A. Roads, 1035 La Cresta Dr., Freeport, Ill. 61032—*Pediatrics* ◄



MEDICINE AT LAW

Damages Awarded for Hospital Visitor's Fall—Damages totaling almost $2,500 against a hospital for injuries sustained when a visitor fell near the entrance to the emergency room were not so grossly inadequate as to require a new trial, the Kansas Supreme Court ruled. A verdict was properly directed for a contractor doing construction work in that area, since the fall was not due to any negligence on the contractor's part.

The woman came to the hospital at 10:30 p.m. She followed a driveway that had been torn up to the emergency room entrance. Just as she was about to enter, she stepped in a hole or "gouged-out" place and fell. There were no lights in the entrance area because the power had been interrupted due to the construction work going on in the area.

The woman contended that the hospital and the contractor were negligent in allowing the hole to exist at the emergency room entrance and in failing to light the area adequately. It was not necessary to determine whether there was sufficient evidence to sustain a finding that the creation of the hole was due to negligence on the contractor's part. The jury found that inadequate lighting was the direct cause of the woman's fall and injuries. The evidence permitted no inference of any negligence on the contractor's part with respect to lighting the entrance area. The contractor had properly placed warning lamps around the perimeter of the construction area. It was the hospital's duty to light its exterior entrances. Thus, the direction of the verdict for the contractor was proper.

The woman contended that the damages awarded against the hospital, which coincided exactly with her medical expenses, were grossly inadequate and were the result of passion and prejudice. In practical effort, however, the woman received greater benefits than the damage award, because the jury also denied the hospital's counterclaim against her for services rendered. The damage award does not necessarily mean that the jury made no allowance for loss of earnings or pain and suffering. The jury may have considered the medical bills excessive or believed that some of the injuries claimed by the woman were caused by something other than the fall.

The fact that the jury considered the possibility after finding out from the telephone directory that the woman was in the insurance business, that she might be trying to recover twice for the same injuries was not ground for a new trial. There was nothing to show that this misconduct prejudiced the woman.—*Furstenberg v. Wesley Medical Center*, 436 P.2d 369 (Kan., Jan. 27, 1968).

Physicians' Speciality Listings In Telephone Directory—Physicians are entitled to have their names listed in the telephone directory under a heading denoting the specialty in which they engage, a Florida trial court ruled. The telephone company and the county medical society were enjoined from eliminating publication of specialty listings in the telephone directory. The society was also enjoined from disciplining a physician, or refusing him membership, because of his telephone listing, if the listing complied with the court's order. Before the judgment became final, the clerk of the court had been ordered to mail a copy to every practicing physician in the county, giving him two days to file objections.

The society had, by a vote of its membership, adopted a rule providing that physicians' names should be listed alphabetically in the classified section and permitting the physician's name to be followed by the statement "practice limited to—." The guideline adopted by the Judicial Council of the AMA, which permitted subject to certain limitations, directory listing under specialty headings was not submitted to the society's membership. In a physician's suit contesting the rule adopted by the county society, the physician contended that the rule affected physicians' rights to contract and to practice medicine and violated their constitutional right to due process of law. Agreeing that the rule was unconstitutional, the court said that it had jurisdiction of the suit because the matter affects "the public interest, health and convenience."

The court ordered that the specialty listings be subject to the following limitations: (1) The specialty headings shall be in accordance with the AMA list of recognized specialties. (2) No physician shall subscribe to specialty headings of more than two specialties. (3) In order to qualify for listing under a specialty heading, a Board-certified physician must furnish the telephone company with a copy of his certificate or a letter stating that he is Board-certified. (4) A physician who is not Board-certified will qualify for listing under a specialty

heading by furnishing the telephone company with a letter stating that he has met the requirements for certification, except for the Board examinations. (5) A physician engaged in "general practice" may list his name under such specialty heading without furnishing any evidence of Board certification or Board qualification therein. (6) A physician may, without regard to Board qualification, list after his name in the general alphabetical listing as many as two specialties. (7) After any specialty listing, either under a specialty heading or in the general alphabetical listing, an appropriate limitation of the specialty to a particular area of the body may be inserted.—*Samartino v. Dade County Medical Association, Inc.*, Cir. Ct., Dade Co., Docket No. 7630 (Fla., June 22, 1967).

Antibiotic Sensitivity Disc Not Drug—A shipment of antibiotic sensitivity discs which were neither certified nor exempt from certification could not be condemned on the ground that it was "misbranded." The disc is not a "drug" within the meaning of the Federal Drug Control Act, a federal appellate court ruled.

No part of the disc is administered, either internally or externally, to man or other animals. It is used in hospital laboratories and clinical practice to test the sensitivity or reaction of a specimen drawn from a patient to each of the antibacterial units contained on the disc, thus furnishing physicians with information which enables them to treat diseases previously diagnosed. The only provision of the Act which could possibly apply to the disc is the subdivision which defines "drug" as an article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals. The disc has nothing to do with diagnosis or prevention of disease. It is not intended, in itself, to be used to cure, mitigate, or treat disease; it merely furnishes information to aid in the cure, mitigation, or treatment of disease. Congress did not intend to apply the phrase "intended for use in the cure, mitigation, or treatment of disease" in such an indirect manner.

The conclusion that the disc was not a "drug" was buttressed by the fact that the compilers of the official compendia of drugs do not consider it a drug. There was also expert medical testimony that the profession limits the concept of "drug" to articles administered to man or other animals, either internally or externally.

Cases in which such substances as honey, mineral water, cigarettes, peppermint leaves, and human blood have been held to be drugs were not in point. Whole human blood which may be used in transfusions clearly comes within the Act. The other substances were held to be drugs because the advertising of them as having therapeutic value indicated that they were intended for use as drugs.

The Food and Drug Administration has attempted to issue regulations applicable to antibiotic discs. The failure of the disc's manufacturer to seek judicial review of the regulations did not preclude it from raising the issue of the Act's applicability to the disc.—*U.S. v. An Article of Drug*,—F.2d—(C.A. 6, March 28, 1968).

Father Guilty of Manslaughter for Not Furnishing Medical Care—A father's conviction for involuntary manslaughter for causing the death of his four-month-old son by failing to furnish him with necessary medical attention was affirmed by the Indiana Supreme Court.

The cause of the child's death was pneumonia, secondary to malnutrition. There was evidence that for several weeks before his death the flesh on the child's legs was lying in folds, he had bleeding sores on his body, and his penis was covered with pus. There was also testimony that the child was fed only common dairy milk and was not kept clean. There was no evidence that the child was given any medical attention.

The father did not fulfill his statutory duty merely by providing sufficient money to support the child. A parent's duty of care is more extensive than mere monetary support. The father contended that his conviction was improper because he did not know, or could not tell, that the child was sick. The father had four other children. The most cursory examination by an experienced parent would have revealed the child's sickly condition. If the father failed to observe the obvious, it could only have resulted from his own negligence.—*Eaglen v. State* of *Indiana*, 231 N.E.2d 147 (Ind., Nov. 22, 1967).

Hospital and Ambulance Service Liable for Patient's Fall—Verdicts of $37,500 for a patient and of $10,000 for her husband in their suit against a hospital and an ambulance service for injuries resulting from her fall from a cot in the hospital were affirmed by a Florida appellate court. The verdicts were not so excessive as to shock the judicial conscience, the court said. The evidence was sufficient to support a finding that both the hospital and the ambulance service were guilty of negligence which contributed to the injuries. The evidence did not raise a question for submission to the jury of contributory negligence on the patient's part.

The ambulance service brought the patient to the hospital and placed her on a cot in a room off the emergency entrance to await assignment to a room. The patient was not an emergency case. She was very ill and was irrational or unconscious. She fell from the cot and fractured her hip.

All that would have been necessary to make the question of contri-

butory negligence on the patient's part one for submission to the jury was some evidence tending to show that she was contributorily negligent. All of the evidence established that the patient was unconscious or semiconscious just before her fall. The only way in which she could have contributed to her fall would have been to regain consciousness sufficiently to realize her condition and thereafter unbuckle the safety belt designed to prevent her from falling. There was no evidence to that effect.—*Bess Ambulance, Inc. v. Boll*, 208 So.2d 308 (Fla., March 19, 1968).

Use of Lead Base Paint Not Negligence—A tenant was denied damages from his landlord for the death of his 2-year-old daughter from the ingestion of lead base paint which had peeled from the woodwork of the apartment. The landlord was under no duty to make repairs and under the circumstances, the use of lead base paint did not constitute actionable negligence, the Pennsylvania Supreme Court ruled.

The complaint alleged that the landlord was negligent in allowing the woodwork paint job to deteriorate to the point where the paint peeled and fell and that he was also negligent in using lead base paint, which is poisonous if consumed. In the absence of any provision in the lease, a landlord has no obligation to repair the leased premises, to see to it that they are fit for rental, or to keep the premises in repair. Since there was nothing in the complaint indicating that the landlord was under any duty to repair, no liability on his part could be based on his failure to repair the premises or on his allowing the paint to peel.

The use of lead base paint would support liability only if such use constituted the creation of a dangerous condition of which the landlord had knowledge and of which the tenant had no knowledge. The court said that, since it judicially knew that the use of such paint was common and widespread, it could not, in the absence of compelling authority, find that the use of lead base paint constituted negligence. A contrary conclusion would require ascribing to the landlord a knowledge and expertise not ascribable, at least at the time of the incident, to people without special training and experience.—*Kolojeski v. John Deisher, Inc.*, 239 A.2d 329 (Pa., March 15, 1968).

Results of Breathalyzer Test Inadmissible—In a prosecution against a driver for drunken driving, evidence that a Breathalyzer test to which he voluntarily submitted showed a blood-alcohol content of 0.18% was improperly admitted, the Ohio Supreme Court ruled.

The driver was arrested when he was found, with the odor of alcohol on his breath, seated behind the wheel of his car, which was parked on private property. The motor was running but the lights were out. He made no objection to going to the police station, where the test was given.

The admission of the test results was improper because there was no evidence that the machine was in proper working order or that the operator was qualified to operate it, other than his bare statement that he was. There was also no evidence explaining the meaning of a blood-alcohol content of 0.18%. Nor was there any evidence showing that the driver had done any driving at or about the time that it was claimed that he was under the influence of intoxicants. There was thus not sufficient evidence to sustain the driver's conviction.—*City of Mentor v. Giordano*, 224 N.E. 2d 343 (Ohio, March 15, 1967).

Plastic Surgeon Liable for Failure to Remove Wrinkles—A model who sometimes works in the nude won a professional negligence suit against a plastic surgeon who failed to keep an alleged promise to remove wrinkles around her navel so she could continue modeling.

The model claimed that the plastic surgeon promised to make incisions of two inches each in the side of her hip line to hide the scars but instead made them 10 and 13 inches long, extending into the groin, so that the scars were visible. She also charged that the wrinkles were not eliminated.

A physician who assisted at the operation testified in favor of the patient. Before the trial, the operating surgeon died, but a lawyer for his estate contended that before the surgery was done, the model fully agreed to accept the results.

The first jury who heard the case was deadlocked, but the second jury after viewing pictures of the woman's abdomen before and after surgery, awarded $16,250 to the model. —*Windsor v. Estate of Dr. Oscar J. Becker*, Cir. Ct., Cook Co., Docket No. 63S-4182 (Ill., March 28, 1968).

Physician Not Liable for Injuries During Examination—A physician was held not liable for injuries suffered by a patient who alleged that she fell from the physician's examining table. The physician said that he had carefully removed the patient from the examining table to the floor to prevent her from falling. The trial court directed a verdict in favor of the physician.

The patient fainted at work and was taken to the physician's office. She claimed that while on the examining table she fainted again and fell to the floor, suffering painful head and back injuries, a chipped tooth, and a concussion. The physician's nurse, however, testified that when the patient began to writhe uncontrollably about the examining table, the nurse and the doctor carefully lowered her to the floor so that she would not fall.—*Nelson v. Callahan*, Cir. Ct., Cook Co., Docket No. 67M4-10364 (Ill., March 20, 1968).◄

ABSTRACTS, BOOK REVIEWS

INTERFERON

Edited by G. E. Wolstenholme and Maeve O'Connor, Ciba Foundation Symposium, Little, Brown & Co., Boston, 1967; 271 pages with numerous illustrations; $12.00.

Ever since Alick Isaacs discovered the existence of this virus-inhibiting substance a decade or so ago, more and more virologists and immunologists have been working on this particular scientific frontier attempting to make sense of this non-toxic, nonspecific product of virus infected cells. How is it created? How does it neutralize viral processes? What is it? How do carcinogens affect it?

Well! Almost a score of eminent investigators gathered to discuss the topic. They were there also to honor the memory of Prof. Issacs who had died earlier in the year while still a young man in his forties.

The data sifted over by the eminent Nobelists and what have you is still too disjointed to make sense to even the specialist in this field. It may be good to ponder on the meaning of statolon. I am sorry that the panelists could not as much as present us with a tentative definition of the very word, interferon. In another ten years, we'll be able to hold a symposium that will clarify the topic. As of now, this collection of rather random and varied musings served only to bewilder me.

No matter how good the paper, binding and editing: I fail to see what purpose was served by the publication as presented.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

PEDIATRIC THERAPY

Shirkey, H. C., 3rd Edition, The C. V. Mosby Company, St. Louis, 1968.

Shirkey's *Pediatric Therapy*, the first edition of which appeared in 1964, has achieved phenomenal success. Much of the success of this book is explained by the background and personality of the editor, so well described in the introduction to the first edition by A. Ashley Weech, M.D. For Dr. Shirkey is essentially a clinician — and a stunningly good one! Hence the whole focus of the book is on clinical medicine and on the practical problems that confront physicians who treat children.

In emphasizing therapy, the book points out that diagnosis is not enough. The 89 authors are authorities in their fields and come from all over the country. They were thoughtfully chosen by the editor for one purpose — their ability to write clearly, authoritatively and practically on the assigned topic. The writing is excellent, the editorial style well coordinated. Like other Mosby books, the quality is superior, the paper good, the type easy to read.

Shirkey's practice of photographing all cases of clinical interest over the years is reflected in the rich use of excellent illustrations. One suspects many of them were taken by Shirkey himself. Two tables are especially noteworthy! One is the tabulation on *Common poisons: symptoms and treatment*, in the chapter by Jay M. Arena. The other is the *Table of drugs* in one of Shirkey's many chapters. It covers doses, generic and trade names, contraindications for use, warnings, cautions, toxicity and how the drugs are supplied. Not only dosage by weight, but also by surface area is given.

Shirkey is an industrious and painstaking editor. As would be expected, the third edition of *Pediatric Therapy* represents a thorough revision, with the addition of some seven new chapters. *Pediatric Therapy*, a major contribution of the widest possible usefulness, should be in the library of every physician who treats infants and children. It should prove of immense usefulness for reference by other members of the health team concerned with pediatrics.

W. D. SNIVELY, JR., M.D.
Evansville

SURGERY OF THE AGED AND DEBILITATED PATIENT

Edited by John H. Powers, Saunders Co., Philadelphia, 1968; 611 pages; numerous illustrations; 24 contributors; $19.00.

This is one of those rather rare volumes where the reader receives *more* than is promised. Far more than just "surgery" is presented to the buyer of this monograph.

"The Physiology of Aging" is followed by a chapter on "Pathogenesis of Diseases of Senescence." Both discussions are compact, comprehensive and most thought evoking. Then, author after author presents his particular facet of the problems we face when treating the aged.

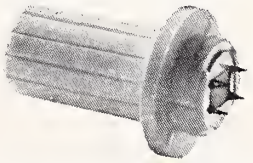
On p. 368, Dr. Dunphy gives "A Bit of Philosophy" anent the doctor "playing God." These couple of pages are well worthy of repeated readings: I think I could almost memorize them with great profit to myself and others.

Drs. Dasco and Lee give very well and compactly a discussion of "Rehabilitation after Major Surgery and Serious Trauma."

All-in-all, this is a book that deserves a place by the bedside of

Continued

Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?
or
HISTO?
(Histoplasmosis—"The Masquerader")



A new aid in differential diagnosis
HISTOPLASMIN, TINE TEST
(Rosenthal)
The LEDERTINE™ Applicator with the Blue Handle

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle

Ask your representative for details or write Medical Advisory Dept., Lederle Laboratories, Pearl River, New York 10965. 406-3

Continued

all physicians: for reading and re-reading in our spare moments. The type is clear, the paper is good and the binding is excellent.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

THE COUNTRY DOCTOR AND THE SPECIALIST

Fred Lyman Adair, M.D., Maitland, Fla., Maitland Award Fund, B.65; 215 pp.; illustrated.

This interesting book is an autobiography of an eminent physician, a great teacher and a fine gentleman. The book is dedicated to Dr. Adair's father, Joseph Lyman Adair, who was a surgeon in the Civil War and an outstanding country doctor at Anamosa, Ia. Dr. Adair grew up as the only child in the family and was a close observer of his father in his country practice.

The father was a staunch Republican and Dr. Adair was given an insight into politics at the time of his boyhood. He graduated from the local high school in 1894 and entered the University of Minnesota for college work and three years of medicine, then transferred to Rush Medical in Chicago where he graduated in 1901 and served an internship at Michael Reese Hospital. He considered the possibility of continuing his father's practice at Anamosa, but rural practice had no attraction for him. He decided to return to Minneapolis where he engaged in general practice after spending another year at the medical college of the University of Minnesota in order to qualify for a Minnesota license.

The elder Dr. Adair passed away in 1902. During Dr. Adair's first years in Minneapolis, he also gave anesthetics and did laboratory work for other physicians. His good friend, Jennings Letzenberg, who also became a noted obstetrician, was on the faculty of obstetrics and gynecology at the University of Minnesota and was responsible for obtaining for Dr. Adair the home delivery service.

Home delivery calls were not always convenient with a horse-and-buggy so he usually used the horse-drawn street cars. He developed a special interest in obstetrics and decided to go to Europe to further his knowledge in that specialty. In 1908 he and his mother made the trip visiting the larger clinics, but he spent most of the year in Berlin. When returning to Minneapolis, he limited his practice to obstetrics and gynecology, and was the first in the city to take such a step.

In 1911 he married Myrtle Ingalls who came from Maine. She served for several years as a receptionist and secretary for the group of physicians with whom he was associated. This marriage turned out to be a very happy union. Their three children were all born at home.

In 1926 he was appointed Chief of the Obstetrical and Gynecological Service at the Minneapolis General Hospital and was made a full professor on the University of Minneapolis faculty.

With the entrance of the United States into World War I, he volunteered for foreign service with the Red Cross and in 1918 left for a year in France and Belgium, where he set up prenatal clinics and established medical social service. For these endeavors he received the Croix Civique Premier from King Albert. In 1929, following Dr. DeLee's retirement, he was offered a professorship at the University of Chicago. He accepted this position after considerable deliberation.

Dr. Adair assembled a staff and the New Lying In Hospital was opened in May, 1931. There he had an opportunity to do some research to which he had looked forward for many years. His first work there was on the active principle of ergot. From

Continued

TAO®(triacetyloleandomycin)
Brief Summary

INDICATIONS: Include streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents.

CONTRAINDICATIONS: Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug.

PRECAUTIONS: CAUTION: USE OF THIS DRUG MAY PRODUCE ALTERATIONS IN LIVER FUNCTION TESTS AND JAUNDICE. CLINICAL EXPERIENCE AVAILABLE THUS FAR INDICATES THAT THESE LIVER CHANGES WERE REVERSIBLE FOLLOWING DISCONTINUATION OF THE DRUG.

Not recommended for prophylaxis or in the treatment of infectious processes, which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgment dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

ADVERSE REACTIONS: Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions.

ROERIG Rx

J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017

This advertisement for TAO® (triacetyloleandomycin), published at the request of the Food and Drug Administration, replaces a recent one which the FDA regards as misleading.

The advertisement headlined "new evidence for TAO . . ." and emphasized that the drug is "for the frequently seen respiratory infection in the office and for a problem pathogen* in the hospital. *Staphylococcus aureus."

We emphasize that triacetyloleandomycin is to be used only for acute, severe bacterial infections where adequate sensitivity testing has demonstrated susceptibility to this drug and resistance to other less toxic agents. In view of the possible, but reversible, jaundice and hepatotoxicity of this drug, other less toxic agents should be used unless the organism is resistant to those agents, or in those cases where hypersensitivity precludes their use.

TAO is contraindicated in preexisting liver disease or dysfunction, and in individuals who have shown hypersensitivity to the drug.

The advertisement emphasized that no tooth staining has been reported after ten years of use of this antibiotic. The Food and Drug Administration regards this claim as an implied comparison suggesting that triacetyloleandomycin and tetracycline have a similar antibacterial spectrum of effectiveness, and that TAO has less toxic potential. Any such implication is not intended and, of course, would be invalid.

The advertisement referred to a research study in which patients were given triacetyloleandomycin prior to determining the susceptibility of the offending organism. Any suggestion that triacetyloleandomycin be used clinically without first determining susceptibility of the offending organism should be disregarded.

ROERIG Rx

J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017

Continued

these investigations came the familiar preparation, Ergonovine. Dr. M. Edward Davis was closely associated with him in this work. Dr. Edith Potter joined the staff in 1934 and carried on extensive research on pathology of the fetus.

As a result of Dr. Adair's efforts, the American Committee of Maternal Welfare was organized. He also was one of the founders of the American Board of Obstetrics and Gynecology and served on the Board for 10 years. One interesting chapter tells of his trip to Argentina.

He retired from the University of Chicago and took residence on a 160-acre farm near Chesterton, Indiana. Late in the 1940's, he decided to get away from the cold northern winter and took residence at Maitland, Florida.

The book contains much which is philosophical and interesting reading. Dr. Adair has received many deserved honors and citations. He has done more for maternal welfare than any other living physician.

This book is most pleasant and entertaining reading with a generous touch of worthwhile information. Every physician and most laymen will enjoy reading this life history of a great physician and a fine gentleman with some of the history of modern medicine.

DAVID A. BICKEL, M.D.
South Bend

Abstracts From Various Literature, Prepared by AMA

...THEY CAN WALK AGAIN

• Torpedoed on the Murmansk run —nearly frozen to death in an open boat—both legs lost below the knee—ex-Merchant Marines Michael McCormick and William Morris walked unaided in three weeks. They could look forward with certainty to leading a normal life again. To these men, as to thousands of other Hanger wearers, the phrase "Hanger is a symbol of help and hope" is a concrete truth proven by every day of their future lives.

Hanger PROSTHETICS

1332 N. Illinois St., Indianapolis, Ind. 46202
3108 Burnet Avenue, Cincinnati, Ohio 45229
446 W. Pontiac St., Fort Wayne, Ind. 46807
416 N. Main St., Evansville, Ind. 47711

ACCIDENTAL STRANGULATION OF INTERSTITIAL HERNIA FOLLOWING INGUINAL HERNIORRHAPHY

T. Dass and E. F. Wood (Highland Hospital, Rochester, N.Y.)
Arch. Surg. 96:949-952, (June), 1968.

An unrecognized strangulated interstitial hernia was discovered 48 hours after routine inguinal herniorrhaphy in an 86-year-old man. Repair of an inguinal hernia tends to stenose the neck of a coexistent unsuspected interstitial component, with the likelihood of subsequent strangulation of its contents. Signs of intestinal obstruction, a suprainguinal mass, and shock following inguinal herniorrhaphy strongly suggest the presence of a strangulated interstitial component. Internal digital exploration of the opened inguinal sac at the time of original herniorrhaphy is recommended for detecting any coexistent interstitial loculus. Because of a high mortality associated with erroneous diagnosis of strangulated interstitial hernia, awareness of this condition and early exploration may be vital.

RETROPERITONEAL RUPTURE OF THE DUODENUM FOLLOWING BLUNT TRAUMA

M. C. Deodhar et al. (Christian Medical College, Ludhiana, Punjab, India)
Arch. Surg. 96:963-966, (June), 1968.

Traumatic retroperitoneal rupture of the duodenum is a rare condition. X-ray demonstration of air in the retroperitoneal tissues following blunt abdominal injury suggests such a pathology. At laparotomy the findings of bile-stained posterior peritoneum, emphysema of the transverse mesocolon, and boggy crepitant swelling below the duodenum confirm the diagnosis.

DECOMPRESSION OF ENDOLYMPHATIC SYSTEM IN MENIERE'S DISEASE

G. Buchheim (Clinique ORL, Hospital Cantonal, Lausanne, Switzerland)
Pract. Otorhinolaryng. 30:129-133, (No. 3), 1968.

Surgical treatment of Meniere's disease can be carried out in two different ways depending on different basic principles: partial or total destruction of the labyrinth or decompression of it. Van Fick's operation (sacculotomy) was performed on three patients. In all three freedom from vertigo without loss of hearing was obtained. One of the cases even regained hearing to the same level as in the other ear. Most authors report good results with Van Fick's operation.

MORTALITY AND INFECTION IN EXTENSIVELY BURNED PATIENTS TREATED WITH SILVER NITRATE COMPRESSES

J. S. Cason and E. J. L. Lowbury (Birmingham Accident Hospital, Bath Row, Birmingham, England)
Lancet 1:651-654, (March 30), 1968.

Forty-six patients with extensive burns were treated with silver nitrate compresses, which had been found highly effective in prophylaxis against *Pseudomonas aeruginosa*. The expected mortality in these patients was 21 and the observed mortality was 16. Separate analyses in children under 13 years of age (27) and in adults (19) showed a reduced mortality only in children. Survival time of adults was sometimes very prolonged. Only one patient died with *P aeruginosa* septicemia. The use of silver nitrate compresses and some other improvements in antibacterial prophylaxis was associated with a large reduction in *P aeruginosa* in burns and in blood cultures of patients in the unit. ◄

NEWS NOTES

THE WISE OWL CLUB OF AMERICA COMES OF AGE

Twenty years ago an employee in the St. Louis foundry of ACF Industries, Inc., dropped a slip of paper into the plant suggestion box. Little knowing the impact his message would have on industrial eye safety, he was asking for some kind of recognition for a worker who saved his eyes by wearing eye protection at the time of an industrial eye accident. From his idea developed the Wise Owl Club of America—an effective incentive plan to reduce needless and costly eye accidents by encouraging the widespread use of proper eye-protective equipment.

It was natural that sponsorship of the Wise Owl Club should be turned over to the National Society for the Prevention of Blindness—the oldest voluntary agency in the country dedicated to prevention of blindness. The Society has long been convinced that over 90% of all industrial and school laboratory and shop injuries can be prevented. Through a nation-wide program of professional and public education, research and industrial and community services, the Society is constantly alerting the American public to the need for better eye health and eye safety.

The Wise Owl Club limits its membership to industrial employees who protect their eyes from injury or loss of sight by wearing safety eyewear at the time of an on-the-job eye accident. Each member receives a certificate, a gold lapel pin and a shop badge which identifies him as a Wise Owl. Special citation awards are made to members who save their sight more than once.

Technical progress in industry continues to demand more complicated machines and more advanced industrial processes. These in turn produce additional threats to the eyesight of the men who operate the machines. Every safety director knows that eye accidents are costly in compensation, wasteful of valuable labor skills and, equally important, demoralizing in terms of suffering and economic hardship to the employee and his family. Accidents will always happen. Amid the bustle and activity of the industrial scene, they cannot be entirely prevented. However, the National Society insists that the eye damage caused by these accidents certainly can be prevented if proper eye protection for the job is worn at all times. Wise Owls are living proof of the value of eye protection.

The Wise Owl safety-incentive movement has reached beyond the confines of industry into homes and schools. Employees of organizations which support Wise Owl chapters can now become honorary members of the Wise Owl Club by saving their eyes in an off-the-job accident. A Junior Wise Owl Club has been formed to encourage eye safety among boys and girls, especially those who normally wear glasses.

From its small beginning the Wise Owl Club program has spread across all 50 of the United States. Today there are about 5,100 Wise Owl chapters with more than 40,560 members in every kind of industry. This membership figure represents a savings in compensation payments of about $202.8 million and the total number of eyes saved among Wise Owl Club members is 50,700. The total number of employees in all Wise Owl Club chapters is 6,471,784.

Dr. Lamb Named

Dr. Russell W. Lamb, Indianapolis, has been named "Shriner of the Year" during an award ceremony in the Murat Temple. Dr. Lamb has been an Indianapolis physician and surgeon many years and has been a strong supporter of conservation and civic functions.

Dr. Grant Gives Address

Dr. M. Arthur Grant, Marion anesthesiologist, spoke on "The History and Background of Hypnosis" and members participated in a demonstration at a recent meeting of the American Business Women's Association.

John Shaw Billings History of Medicine Society November Meeting

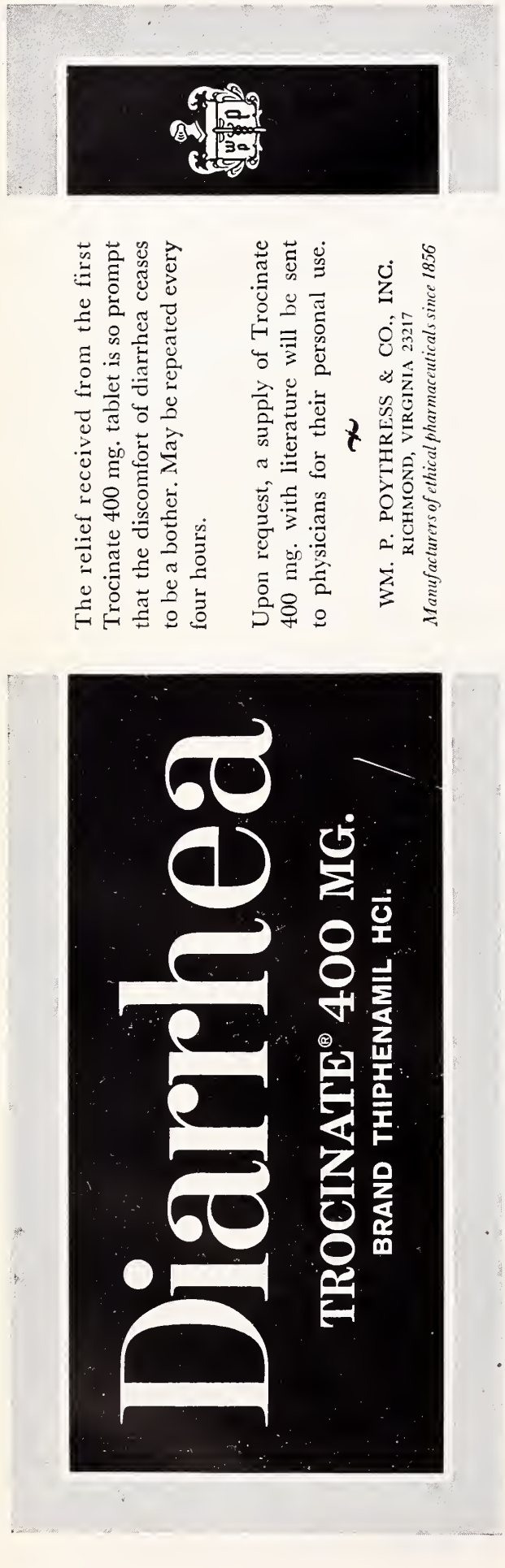
Mr. Lee Hopper, of the Indiana University Medical Center, will be the principal speaker at the November 6th meeting of the John Shaw Billings History of Medicine Society.

His topic will be "Report on the 1968 AAHM Meeting, St. Louis, Missouri." Each program is preceded by a social hour and dinner on the mezzanine of the Student Union Building, Indiana University Medical Center, Indianapolis, beginning at 6:30 p.m.

Dr. Brodie is Speaker

Dr. Donald W. Brodie, Indianapolis, discussed "Alcoholism" at the recent Youth Assembly of the Indiana-Kentucky Conference, United Church of Christ at Indianapolis.

Continued



Dr. Newnum is Speaker

Dr. Raymond L. Newnum, Evansville, discussed "Abortion, Organ Transplants and Treatment of Terminally Ill Patients" at a recent program for clergymen of all faiths in Evansville.

Medical Staff Elections at Various Indiana Hospitals

Dr. Isadore J. Kwitny, Indianapolis, has been re-elected for a second term as president of St. Vincent's Hospital medical staff for 1968. Re-elected vice-president for a second term was **Dr. Harvey W. Sigmond. Dr. John M. Tondra** will serve as secretary-treasurer.

Dr. Mortimer Mann, Indianapolis specialist in ophthalmology, has been elected president of the General Hospital staff. Other officers are: **Drs. Bill L. Martz,** vice-president; **John O. Miller,** secretary and **Arvine G. Popplewell,** treasurer.

Dr. Donald E. Stephens, Indianapolis, has been elected president of the Methodist Hospital medical staff. **Dr. John H. O. Mertz** has been elected vice-president and **Dr. Robert Rudesill**, secretary-treasurer.

Dr. Don Boyer, Lebanon surgeon, has been elected to the Witham Memorial Hospital staff there for 1968. He has been on the staff at the hospital for the last five years and has served as vice chief of staff previously.

Dr. Victor Johnson, Evansville, has been named president-elect of the Deaconess Hospital medical board. At the same time, **Dr. George Willison** took office as president. Others elected include **Dr. Ray Burnikel** as secretary and treasurer.

Dr. Garland R. Garst, Evansville, has been elected president of St. Mary's medical staff. Also elected were: **Drs. Melvin S. Durkee,** chief of staff; **Kenneth J. Rudolph,** vice-president and **Weston A. Heinrich,** secretary-treasurer.

Dr. Robert J. Schmoll, Fort Wayne ophthalmologist, has been appointed head of the medical staff at St. Joseph's Hospital. Other officers are **Drs. Louis Schneider,** president-elect and **Jack Patterson,** secretary-treasurer.

Dr. John W. Rousseau, Fort Wayne, has been named head of the medical staff at Parkview Hospital. **Dr. Arthur F. Aiken** was named president-elect and **Dr. Robert F. Kimbrough,** secretary-treasurer.

Dr. Leonard W. Neal, Munster, has been named president of the St. Margaret Hospital medical staff. **Dr. H. I. Arbeiter** is vice-president and **Dr. Nicholas Egnatz** secretary-treasurer.

Dr. Noel L. Neifert, Tell City, has been elected president of the medical staff of the Perry County Memorial Hospital. Also elected were: **Drs. Hargis Bush,** vice-president and **L. C. Lohoff,** secretary.

Dr. William L. Green, Shelbyville, has been re-elected president of the medical staff of the Major Hospital there. Other officers are: **Drs. John A. Davis,** vice-president and **James H. Tower, Jr.,** secretary. The staff also named **Dr. Joseph Moheban** as chief of medicine.

Dr. Hanneken is Speaker

Dr. Vincent J. Hanneken, Wabash, recently spoke on "Cystic Fibrosis, Birth Defects and Effects of Radiation" to Division 5 of Licensed Practical Nurses at the Wabash County Hospital.

Dr. Farmer Named

The Daviess County Board of Health recently announced the appointment of **Dr. Charles R. Farmer, Washington,** as Daviess County Health Officer.

Dr. Hogle on Panel

Dr. Frank D. Hogle, North Webster, participated recently as a panel member in a School Health Conference held at Goshen College. The subject of the panel was "Problems with Senior High School Age Group."

Dr. Kirtley Elected

Dr. J. Marion Kirtley, Crawfordsville, has been elected president of the Montgomery County Historical Society.

Dr. Adler is Speaker

Dr. David L. Adler, pathologist at Bartholomew County hospital, recently spoke to the Columbus Kiwanis Club at Donner Center.

Dr. Green Gives Address

The "Diagnosis and Treatment of Epilepsy" was the subject of the talk delivered by **Dr. Joseph B. Green,** of the Indiana University School of Medicine Department of Neurology, Indianapolis, at a recent meeting of the St. Joseph County Medical Society at South Bend.

National Fire Protection Association Publishes Booklets

The National Fire Protection Association has just published two booklets of interest to physicians in hospital service.

"Standard for Inhalation Therapy" is a 28-page manual on the fire, chemical and mechanical hazards with oxygen-enriched atmosphere (except hyperbaric chambers). Its price is 75 cents.

"Code for the Use of Flammable Anesthetics" is a 68-page book concerning prevention of fire around anesthetic apparati. It sells for $1.25. Address the Association at 60 Batterymarch St., Boston 02110.

Dr. Kirtley is Speaker

Dr. William Kirtley, director of medical research at Eli Lilly and Co., Indianapolis, was guest speaker at a recent meeting of the Howard County Diabetes Association. His topic was "Diabetes Therapy: Present and Future."

Doctors Honored For Service

Drs. David G. Wagner and George S. Westfall, Goshen, were presented pins commemorating their volunteer service to the Red Cross Blood Program by the Goshen Chapter of the American Red Cross, at a recent meeting of the Goshen General Hospital medical staff.

"An Environment Fit for People" Pamphlet Now Available

Public Affairs Pamphlet No. 421, "An Environment Fit For People", is a 28-page discussion of environmental contamination published in cooperation with The Conservation Foundation.

The author, Raymond F. Dasmann, points out that the problem is so worldwide now that the old custom of moving away from the contamination is no longer feasible; real answers are

Continued

HARDING HOSPITAL

WORTHINGTON, OHIO

A fully accredited private psychiatric hospital situated on 45 acres of beautiful, wooded grounds just ten miles north of the state capitol.

THE HARDING HOSPITAL PROVIDES:

* 125 In-patient beds —
* Day Hospital program —
* Full time attending staff of psychiatrists —
* Professionally trained Adjunctive Therapy staff with programs in occupational, recreational and vocational therapy. (Crafts, Fine Arts, Greenhouse, etc.)
* Qualified staff of psychologists —
* Social Service department —
* Consultation and evaluation for out-patients.

For particulars on rates and terms or on specific patients write or call —

Harding Hospital - Worthington, Ohio
Area Code 614 - 885-5381

George T. Harding, M.D.
Medical Director

Donald L. Hanson
Administrator

needed. The pamphlet sells for 25 cents (discount in quantities). Write Public Affairs Pamphlets, 381 Park Ave., South, New York City 10016.

Dr. Applegate is Moderator

Dr. George W. Applegate, Indianapolis, assistant director of medical education, recently moderated a three-man panel which discussed the most frequently encountered emotional disorders, at a seminar in Indianapolis. It was sponsored by the Methodist Hospital Graduate Medical Center and was designed to assist practicing physicians in the diagnosis and treatment of anxiety and depression.

Dr. Harrison Named

Dr. Benjamin L. Harrison, New Castle, has been named Outstanding Citizen of the Year by the Business and Professional Women at their annual Civic Night Dinner. The distinction comes to Dr. Harrison as he rounds out 40 years of service to his community.

"Breathing" Booklet Available To Physicians for Patients

"What You Can Do About Your Breathing" is the title of a booklet prepared under the sponsorship of Indiana Tuberculosis Association for use by physicians in instructing patients with various types of chronic obstructive respiratory disease.

It is printed in large type and has numerous illustrations, and spaces are provided for the writing of special instructions by the physician. The booklet will be supplied to physicians, nurses, inhalation therapists, physical therapists and others concerned with respiratory disease. Funds supplied by Christmas Seal contributions allow its distribution without cost.

Dr. Salon Re-Elected

Dr. Joel W. Salon, Fort Wayne, has been re-elected chairman of the Department of Medicine at St. Joseph's Hospital and **Dr. Donald J. Parrot** will head the Department of Obstetrics-Gynecology.

Dr. Antreasian is Delegate

Dr. Berj Antreasian, Indianapolis, recently was a delegate to the regional meeting of the American Society of Internal Medicine in Phoenix, Arizona. He represented the Indiana Society of Internal Medicine.

Doctors and **Nurses**

White Conductive Shoes for surgery
—Nurses & Doctors shoes for all occasions
—ORTHOPEDIC shoes for
Men-Women-Children

Shoe Prescription Service by Heidenreich & Son

Heid's

HEALTH SHOE STORE
411 N. ILLINOIS
DRIVE-IN PARKING
INDIANAPOLIS, IND.

AFNB—Midwest Charge
ME5-4247

University of California Announces Master of Public Health Degrees

The University of California at Berkeley through its Division of Maternal and Child Health announces programs leading to the degree of Master of Public Health.

The courses in Maternal and Child Health, Family Planning, and School Health are each of nine months duration. The course in The Multiply Handicapped and Mentally Retarded Child is a 21-month program. The course in Career Development Programs is three years in length. Tax-exempt fellowship support is available.

Applications are being taken now for the group entering in July or September, *1969*. Write Helen M. Wallace, M.D., School of Public Health, University of California, Berkeley 94720.

Drs. Senseny and Haley on Panel

Drs. Eugene F. Senseny and Alvin Haley, Fort Wayne, were recent panel members at the Allen County PTA Council meeting which discussed "Do We Educate Our Children for Family Living."

Dr. Hare Appointed

Dr. Daniel M. Hare, Evansville urologist, has been named to the board of the Evansville-Vanderburgh Health Department by Mayor Frank McDonald, to fill an unexpired term that runs through 1970.

New Monthly Newspaper for Physicians in Group Practice

Medical Group News is a new monthly newspaper devoted to the interests of physicians in group practice. It will be edited by Edwin P. Jordan, M.D., who was founding executive director of the American Association of Medical Clinics for 18 years.

The nine-member advisory board contains Dr. W. D. Snively, Jr., Evansville, and Dr. George B. Plain of South Bend. The newspaper is independent, will be supported by medical advertising, and is an enterprise of Global Medical Press, Inc.

Dr. Ress is Speaker

Dr. Gene Ress, Tell City, recently spoke at the meeting of the Perry County American Cancer Society there. He spoke on "Symptoms, Treatment and Scientific Research Developments of Cancer."

Dr. Newnum Speaks

Dr. Raymond L. Newnum, Evansville, recently spoke on "Moral Issues in Indiana Medicine Today" at a interdenominational program at St. Mary's Hospital. Dr. Newnum is chief of medicine at St. Mary's.

Fire Safety for Hyperbaric Facilities Subject of Pamphlet

Fire safety for hyperbaric facilities is the subject of a new pamphlet published by the National Fire Protection Association. The 44-page booklet outlines the tentative standards which have been developed for research and treatment facilities which utilize oxygen under greater than atmospheric pressure. The price is $1.25. The address is 60 Batterymarch St., Boston 02110.

Dr. Wise Re-elected

Dr. Charles L. Wise, Camden, has been re-elected chairman of the Carroll County Board of Health.

Dr. Dumanian is Speaker

Heart specialist, **Dr. Ara V. Dumanian, Homewood, Illinois,** recently was guest speaker at a meeting of the Highland Woman's Club. A movie on open heart surgery was shown and the doctor conducted a discussion period.

Santa Clara Medical Society Originates New Training Program

The Santa Clara County Medical Society, (California), has originated a training program for the purpose of educating 50 discharged medical corpsmen for civilian paramedical jobs. A grant of $39,500 has been received to cover activities for the first year.

Dr. Schoen Appointed

Dr. Frederic L. Schoen, Fort Wayne, has been appointed to a three-year term on the Commission on Environmental Medicine of the American Academy of General Practice.

Dr. Burkle Inducted

Dr. Robert J. Burkle, Terre Haute, was recently inducted as a Fellow of the American Academy of Orthopedic Surgeons at the group's annual meeting in Chicago.

New Ames Director

Morton Alpert, Ph.D., at one time Associate Professor of Anatomy at Indiana University School of Medicine, and recently Consultant to the Office of Scientific and Technical Equipment of the U. S. Dept. in Washington for the administration of the Florence Agreement, has been appointed to the position of Director, Clinical Sciences, Medical Department, Ames Company, Division Miles Laboratories.

Dr. Davis is Speaker

Dr. William H. Davis, New Market, spoke on "Mental Health" at a recent meeting of the Pi Chi Chapter of Pi Omicron National Sorority. A question-answer session followed.

Dr. Forchetti Elected

Dr. John A. Forchetti, Chesterton, has been elected to active membership in the American Academy of General Practice.

Zimmer Manufacturing Company Continues Clinical Fellowships

The Zimmer Manufacturing Company of Warsaw will continue its generous support of a clinical fellowship in orthopedic surgery at I.U. School of Medicine. Their $3,500 grant annually pays for four Senior Student Fellowships at $750 each with an additional $500 to cover transportation and administration expenses.

Dr. Thomas Horwitz is director of the project. The arbeit concerned is carried out during the students' "off quarter." It was established last year and is continued because it has proven to be an outstanding exercise in undergraduate training.

Dr. Bennett Returns

Dr. J. B. Bennett, Warren physician, has returned from 60 days of voluntary civilian medical service in Vietnam.

Dr. Dukes Elected

Dr. Betty Dukes, Dugger, has been elected president of the board of directors of the Katherine Hamilton Mental Health Center.

Continued

Q. How much does the **anticostive* hematinic** cost?

A. No more than costive hematinics cost!

The anticostive hematinic is

PERITINIC®

Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:	
● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

*

anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

490-7R- 6064

Continued

SFK Publishes 1968/1969 Catalog Listing Services

Smith Kline & French Laboratories have just issued the 68/69 edition of their SK&F Services Catalog. Its 58 pages list all the SK&F services which are available to physicians without charge.

Medical films, booklets, periodicals, medical color television, speakers bureau, and the "Code 4" cardiopulmonary resuscitation training program are all listed with brief descriptive data. The catalog may be obtained from any SK&F representative or by writing to their Services Department E-10, 1500 Spring Garden St., Philadelphia 19101.

Dr. Rosenbloom is Speaker

Dr. Philip J. Rosenbloom, Gary health commissioner, recently discussed present services offered by the Gary Department of Health; the possibility of establishing maternal and child health clinics and out-clinics in neighborhoods and hospitals and narcotics rehabilitation at the Roosevelt Neighborhood Action Council, Gary.

Dr. Dierdorf Gives Address

Dr. Fred Dierdorf, Terre Haute, recently addressed the Wabash Senior Citizens on the subject of "Anesthetics." Dr. Dierdorf is a specialist in that field.

I went through med school on a shoestring, but fortunately it was wrapped around $10,000 my aunt left me!

Ball State University Submits Budget for Two-Year Medical School

Ball State University has submitted budget requests to co the establishment and operation of a two-year medical sch designed to open with 32 first year students in 1970.

The program is reported to anticipate costs of $139,500 1969-70 and $234,500 for 1970-71. The costs are considered l since many of the existing facilities at Ball State may be utiliz

Dr. Paris Re-appointed

Gov. Roger D. Branigin recently reappointed **Dr. John Paris, New Albany,** to the Commission for Special Institutio in the State Board of Health.

Dr. Weinstock Honored

Dr. Adolph Weinstock, Rolling Prairie, recently receiv a 10-year attendance award at the annual Scientific Assem Seminar for Physicians in Chicago.

Medical Librarian Named

Miss Ann Kerker, medical librarian of Purdue Universit School of Veterinary Science and Medicine, has been nam treasurer of the national Medical Library Association. M Kerker is president-elect of the Indiana chapter, Spec Libraries Association.

Dr. Palmer is Speaker

Dr. Harley P. Palmer, Franklin pathologist, spoke "Rh Diseases in Newborns" at a recent meeting of the Johns County Memorial Hospital Guild.

Dr. Turner Awarded

Dr. Harold B. Turner, Bloomfield, recently received 25-year pin and certificate for his contribution as medical a viser to the Greene County Selective Service Board.

Dr. Crockett is Speaker

Dr. Wayne Crockett, Terre Haute, spoke recently to t Wabash Senior Citizens' Center, Inc. His topic was "Tired Bloo

Dr. Schenck Gives Address

"Study of the Psychology of War" was the topic chosen **Dr. Ralph E. Schenck, Portland,** when he spoke recen before Jay Area Nurses. He showed slides and based his remar on the Battle of Britain.

Dr. Shelley is Speaker

Dr. Richard J. Shelley, Indianapolis, spoke on resear projects to find causes and make early detection of childho disorders through prenatal conditions and details of birth a recent meeting of members of St. Mary's Child Center Guild.

Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION ANNUAL CONVENTION
Date Dec. 1-4, 1968
Place Miami Beach, Fla.

NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville

INDIANA PSYCHIATRIC SOCIETY
Date Second Wednesday of the month October through May, excluding December
Place The Athenaeum, Indianapolis

AMERICAN COLLEGE OF SURGEONS INDIANA CHAPTER
Date April 17-19, 1969
Place Purdue University, West Lafayette

BONE AND JOINT CLUB
Date October 30, 1968
Place Athenaeum, Indianapolis

INDIANA ACADEMY OF GENERAL PRACTICE
Date April 15-17, 1969
Place Evansville

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
Date April 30-May 1, 1969
Place Imperial House, Columbus

INDIANA ASSOCIATION OF PATHOLOGISTS, INC.
Date December 7, 1968
Place Indianapolis Motor Speedway Motel

INDIANA CHAPTER OF AMERICAN ACADEMY OF PEDIATRICS
Date May 14-15, 1969
Place Stouffer Inn, Indianapolis

INDIANA DENTAL ASSOCIATION
Date May 10-14, 1969
Place Murat Temple and Essex House Motel, Indianapolis

INDIANA PUBLIC HEALTH ASSOCIATION, INC.
Date April 22-24, 1969
Place Stouffer Inn, Indianapolis

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 15-18, 1968
Place Fort Wayne

INDIANA ROENTGEN SOCIETY
Date May 4, 1969
Place Holiday Inn, Indianapolis

INDIANA SOCIETY OF ANESTHESIOLOGISTS
Date May 24, 1969
Place Marott Hotel, Indianapolis

INDIANA STATE LICENSED PRACTICAL NURSES' ASSOCIATION, INC.
Date May 5-9, 1969
Place Robert Lee Motel, New Albany

INDIANA STATE NURSES ASSOCIATION
Date October 16-18, 1969
Place Civic Auditorium, Evansville

INDIANA MEDICAL BUREAU
816 Hume Mansur Bldg.
631-5802

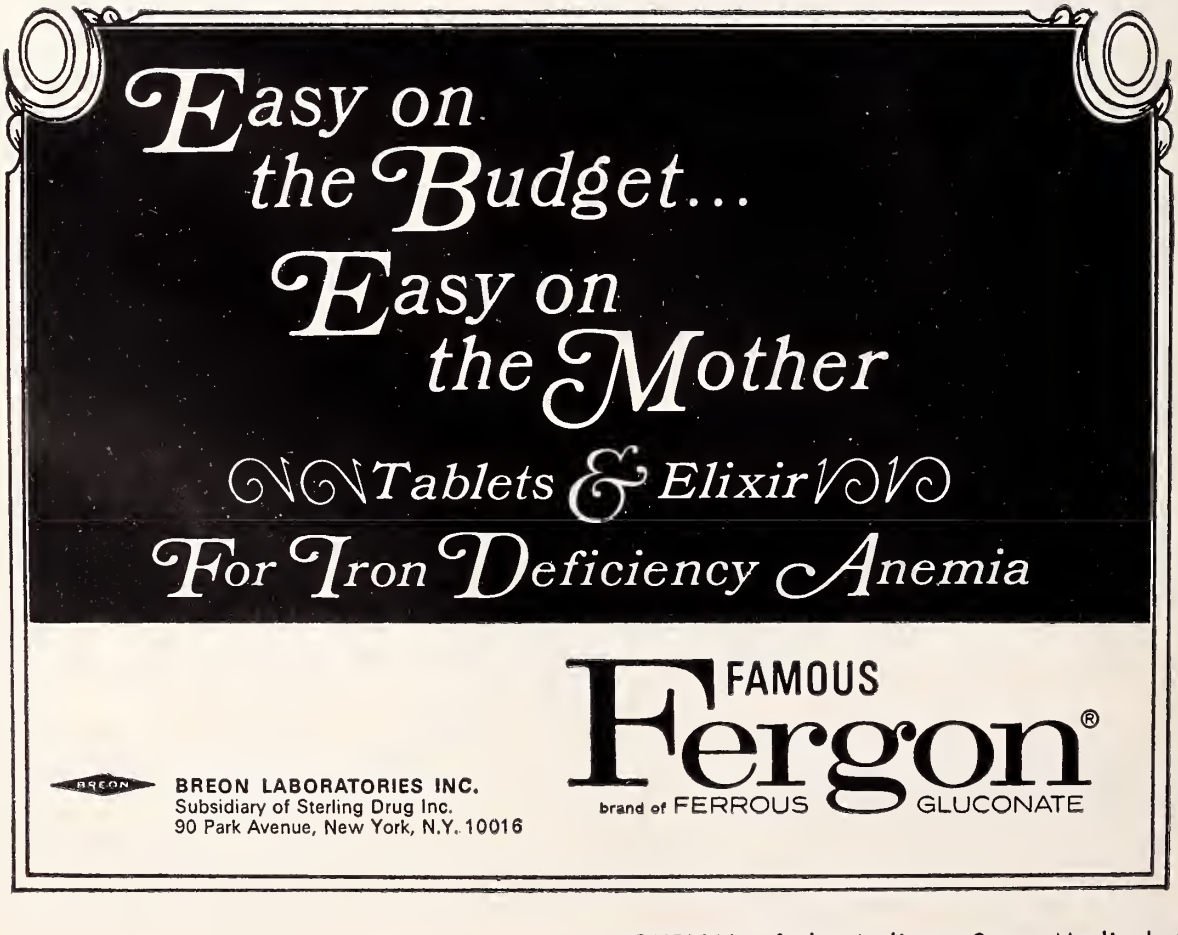
A Licensed Employment Agency
Specializing in Medical Personnel

Our 18th Year Of Service

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—August, 1968

Disease	Aug. 1968	July 1968	June 1968	Aug. 1967	Aug. 1966
Animal Bites	1177	1220	1505	1091	1038
Chickenpox	50	49	185	24	53
Conjunctivitis	94	103	85	47	158
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	50	7	1	22	44
Gonorrhea	640	521	593	428	474
Impetigo	211	108	100	96	221
Infectious Hepatitis	49	47	56	32	21
Infectious Mononucleosis	31	25	53	8	31
Influenza	191	78	189	32	137
Measles					
Rubeola	40	22	69	7	67
Rubella	58	27	63	25	27
Meningitis, Meningococcal	3	0	8	0	7
Meningitis, Other	5	2	9	3	4
Mumps	78	100	234	142	59
Pertussis (whooping cough)	28	15	32	36	23
Pneumonia	90	126	180	92	136
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	438	311	458	250	265
Syphilis					
Primary & Secondary	35	20	25	16	13
All Other Syphilis	145	58	142	66	94
Tinea Capitis	6	8	13	0	12
Tuberculosis (active)	61	83	128	63	83



ectional Meeting of the merican College of Surgeons

Members of ISMA are invited to attend a Sectional Meeting f the American College of Surgeons to be held at Louisville on ebruary 24 to 26, 1969, at the Brown Hotel.

A symposium on trauma will highlight the meeting, with eneral and specialty coverage. The Ob-Gyn and the neuro-rgical programs will be outstanding. A fee of $15.00 is charged physicians not members of the College. Residents are admitted ee upon presentation of a letter of identification from their rvice chief.

ostgraduate Gastroenterology Course isted by Cleveland Clinic Foundation

A course on "Upper Gastrointestinal Disease—Clinical Aspects" ill be conducted at the Cleveland Clinic Educational Foundation n November 6 and 7.

Further information and programs may be obtained by writing the Director of Education, The Cleveland Clinic Educational oundation, 2020 E. 93rd St., Cleveland 44106.

ostgraduate Seminar in Surgery Will be Presented January 15-18, 1969

The University of Miami School of Medicine will present a Postgraduate Seminar in Surgery at the Eden Roc Hotel in Miami Beach on January 15 to 18, 1969.

The subject will be "Art and Science in the Therapy of Difficult Problems in Surgery." A distinguished panel of guest professors will assist the Miami faculty. Write the Jackson Memorial Hospital, P.O. Box 875, Biscayne Annex, Miami, Florida 33152 for further information.

University of Colorado Offers Postgraduate Courses for Physicians

The University of Colorado will conduct a postgraduate course in "Arthritis Syndrome" on November 13 and "Musculo-Skeletal Diseases for the General Physician" on November 14-16.

The program will be presented by both the Colorado faculty and guest speakers. Registration and tuition fees and further information on the course may be obtained by writing Postgraduate Medical Education, 4200 E. Ninth Ave., Denver 80220.

Symposium on "Plastics and the Human Body" Set for November 12-15

A symposium on "Plastics and the Human Body" will be a part of the program of the meeting of the National Plastics Conference at the Conrad Hilton Hotel in Chicago on November 12 to 15.

Dr. Willem J. Kolff will be co-moderator of the session which

in the treatment of
IMPOTENCE

Android®
(thyroid-androgen) TABLETS

*Effectiveness confirmed by another double blind study**

1.SUMMARY
ANDROID — GOOD TO EXCELLENT 75%
PLACEBO — 20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

*"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths

Android
Each yellow tablet contains:
Methyl Testosterone . .2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY
Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY
Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C
Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

Write for literature and samples:
BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

REFER TO PDR

also available with ESTROGEN
Android-E
Each Tablet Contains:
Methyl Testosterone ..... 2.5 mg.
Ethinyl Estradiol ..... 0.02 mg.
Thyroid Ext. (1/6 gr.) ..... 10 mg.
Thiamine Hydrochloride ..... 10 mg.
Glutamic Acid ..... 50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. DOSE: One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. SIDE EFFECTS: In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. CONTRA-INDICATIONS: See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

After the picnic even Gramps Was a victim of intestinal cramps

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric*
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin,
and protects intestinal mucosa

In elderly patients it is particularly important to stop the diarrhea fast. Parepectolin helps you control diarrhea promptly and gain the patient's confidence until etiology has been determined.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) ..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified) .... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.

RORER
WILLIAM H. RORER, INC.
Fort Washington, Pa.

will be on Friday, November 15 from 9 to 12 a.m. The use of plastics in artificial kidneys, as artificial blood vessels, for assisting the failing heart, in construction of hearts and heart valves and in the general cardiovascular field will be discussed.

For more information write The Society of the Plastics Industry, 250 Park Ave., New York City 10017.

Society of Cryosurgery Sets January 12-17, 1969 Meeting

The Society of Cryosurgery will hold its annual meeting at the Hilton Plaza at Miami Beach on January 12 to 17, 1969.

The application of cryosurgery in the specialties of ophthalmology, neurosurgery, otolaryngology, urology, gynecology, dermatology and oncology will be considered. All physicians and surgeons are invited to attend.

Write to Dr. John G. Bellows, 30 N. Michigan Ave., Chicago 60602 for further details.

Second Annual Newborn Symposium Set for November 12-13 in Louisville

The Department of Pediatrics, University of Louisville School of Medicine will present its second annual Newborn Symposium November 12-13.

Participants are Drs. Robert Beargie, University of Kentucky; George Cassady, University of Alabama; Cecil M. Drillien, University of Edinburgh; Frank Falkner, National Institute of Child Health; John Green, Jr., University of Kentucky; Walter Hughes, University of Louisville; Lula Lubchenco, University of Colorado; Duncan MacMillan, University of Louisville; Douglas Shanklin, University of Chicago; John Sinclair, Columbia University; Robert Usher, Royal Victoria Hospital; Myron Winick, Cornell University.

For information write: Dr. Billy F. Andrews, 323 East Chestnut, Louisville, Kentucky 40202.

Diabetes Association of Greater Chicago Sets 11th Annual Symposium

The Diabetes Association of Greater Chicago will conduct its Eleventh Annual Symposium on Diabetes in the Auditorium of the Evanston Hospital, 2650 Ridge Ave., Evanston on Friday, November 15, with registration beginning at 8:30 a.m.

The morning session will be devoted to the discussion of the synthesis and secretion of insulin. The fate of insulin after it leaves its source in the pancreas will also be discussed. The Woodyatt Memorial Lecture will be delivered during the morning session by Dr. Arnold Lazarow. There will be a roundtable discussion at the luncheon recess.

Registration is free for members of the American Diabetes Association, resident house staff members and dietitians. The fee for non-members is $10. Address inquiries to 620 N. Michigan Ave., Chicago 60611. ◄

Deaths

Russell R. Hippensteel, M.D.

Dr. Russell R. Hippensteel, former Indianapolis and Hollywood, Fla., pediatrician, died Aug. 19 at Plymouth. He was 72.

Graduated from the I.U. School of Medicine in 1922, Dr. Hippensteel became assistant superintendent of Indianapolis General Hospital in 1925 and the following year became superintendent of Edwards Hospital at Fort Lauderdale, Fla. In 1927, he returned to Indianapolis and entered private practice, left here to serve in World War II and then returned to Indianapolis and practiced here until 1951.

Dr. Hippensteel moved to Hollywood, Fla., and practiced there until 1961. When he died, he was living at Culver. Dr. Hippensteel was a former ISMA delegate, a Senior Member of ISMA and member of the Marshall County Medical Society.

Edwin E. Kime, M.D.

Dr. Edwin E. Kime, 77-year-old former Indianapolis physician, died May 25 at Bloomington.

A member of the Marion County Medical Society, Dr. Kime was graduated from the I.U. School of Medicine in 1916. He was a specialist in clinical anatomy and physical medicine and served on the staffs of the Indiana University, Methodist and Community Hospitals before his retirement. He was a Senior Member of ISMA and a member of the 50-Year Club.

Leonard Z. Sacks, M.D.

Dr. Leonard Z. Sacks, Porter Memorial Hospital's first full-time pathologist, died Sept. 2 at Valparaiso at the age of 51.

Graduated from the University of Pittsburgh School of Medicine in 1941, Dr. Sacks served as pathologist at Veterans Administration hospitals in Dayton, Ohio and Butler, Pa. Prior to joining the staff of Porter Memorial in 1959, Dr. Sacks was employed for nine years at a Carlisle, Pa., hospital. He was a captain in the U.S. Army Medical Corps during World War II and a member of the Porter County Medical Society.

Wendell A. Shullenberger, M.D.

Dr. Wendell A. Shullenberger, 57, staff physician at Methodist Hospital, died Aug. 28 in his Indianapolis office.

A specialist in internal medicine, Dr. Shullenberger was graduated from the I.U. School of Medicine in 1935. He was assistant professor of medicine, Indiana University School of Medicine; on the visiting staffs of Methodist, St. Vincent's, Marion County General and the Indiana University Hospitals and an attending physician at the Veterans Administration Hospital. He was also a member of the Marion County Medical Society.

Wendell C. Stover, M.D.

Dr. Wendell C. Stover, 57-year-old Boonville physician, died Aug. 18 at the hospital there. He had practiced medicine in Boonville for 32 years.

A graduate of the I.U. School of Medicine in 1935, Dr. Stover went to Boonville in 1936. He was a captain in the 8th Air Force from 1942 to 1945 and served in England. Dr. Stover was a Warrick County and City Board of Health official, an ISMA delegate and member of the Warrick County Medical Society. ◄

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

INDIANAPOLIS OFFICE:

Kenneth W. Moeller and Philip P. Capasso, Representatives

665 East 61st Street Telephone: 317-255-6525

Mailing Address: P.O. Box 20132, Indianapolis 46220

Association News

EXECUTIVE COMMITTEE

August 17, 1968

Meeting called to order at 1:00 p.m. Saturday, August 17, 1968. In the absence of the chairman, Dr. G. O. Larson, president, presided.

Those responding to roll call were: Burton E. Kintner, M.D., G. O. Larson, M.D., P. J. V. Corcoran, M.D., Lowell H. Steen, M.D., M. O. Scamahorn, M.D., Frank B. Ramsey, M.D., James A. Waggener, executive secretary.

Minutes of the July 20, 1968 meeting were approved on motion of Drs. Steen and Scamahorn.

The membership report as of July 31, 1968 was approved by consent.

Full dues paying	3,880
Interns and residents	106
AMA full dues paying	3,733
Full dues paying as of July 31, 1967	3,851
Interns and residents as of July 31, 1967	102

Headquarters Office

The secretary reported on the recent meeting of the Coordinated Information Project for the information of the committee.

Renewal of the Circle Alarm contract was approved on motion of Drs. Steen and Kintner.

The request for the secretary to be a speaker before the new School of Public Health Administration at Indiana University on November 26th was reviewed for the information of the committee.

The proposal of Fisher-Stevens to handle the computerized record system of the association was reviewed and on motion of Dr. Steen and taken by consent, the association will continue on its present program.

Treasurer's Report

The assistant treasurer reported, in the absence of the treasurer, on fund balances and investments. The report was approved by consent.

The action of the Council in appropriating $300 to be budgeted for the acquisition of literature on health matters to be made available to the Commission on Public Information was reviewed and the action of the Council to increase the budget was approved by consent.

Unfinished Business

The secretary reported that the attorney had expressed the opinion that the proposed examination form developed by the Bureau of Motor Vehicles is not a form which would place the physician in any danger of being sued for liability for his completion of such report.

The attorney pointed out that the one question which might be sticky was "Do you believe this person capable of driving a vehicle?" He pointed out that this question was optional with the doctor as to whether or not he would answer and if he did, he did not feel it placed the physician in a position of being liable or subject to suit.

To explain this further, he said it was not the doctor who made the decision but the Bureau of Motor Vehicles. This report was also referred to the Council.

Organization Matters

A letter from the American National Red Cross offering their services to the association concerning any planning of programs in the field of emergency medical services was read, and by consent this is to be referred to Doctor Hillis and his Council committee.

A report was made on the Health Care Conferences which are being held throughout the country.

Bylaws of the Fayette-Franklin-Union County Regional Health Planning Council, Inc., were reviewed by the committee and this is to be referred to Dr. Donato's Council committee for review and any action they desire to take.

The organization chart of the Floyd Comprehensive Health Planning Committee was displayed for the information of the committee.

A letter from the American Medical Association concerning "Legality of Internship Prior to Graduation from Medical School" was reviewed for the information of the committee.

The program and outline of the continuing education programs of the Allen County Medical Society were reviewed for the information of the committee.

A memo from the Indiana Hospital Association concerning Health Facilities Planning Programs in Northern Indiana was reviewed for the information of the committee.

A report in the publication called *The Political Stethoscope* which showed Indiana leading in two of three classifications for physician participation was called to the attention of the committee.

A memo from Dr. Frederic A. Rice, Jr. enclosing a letter from Martz, Beatty and Wallace was reviewed, and, by consent, this information is to be referred to the Commission on Legislation.

A letter from Dr. K. O. Neumann addressed to the Indiana Blue Shield was read for the information of the committee.

A letter was read from Ralph Hamill stating that the Indiana Medical Foundation papers were filed on July 26, 1968.

On motion of Drs. Steen and Corcoran, an editorial from the *Annals of Internal Medicine* on "Smoking" and an article from the same publication on "Saving The Lives of Those Struck by Lightning" were referred to the Public Health and Public Information Commissions. It was also stated that it was hoped these articles could be published in *The Journal of the Indiana State Medical Association.*

A letter from the Indiana Interagency Council on Smoking and Health addressed to Dr. Corcoran was reviewed and, by consent, this letter was also referred to the Commissions on Public Health and Public Information.

A letter addressed to the President, Doctor Larson, from Mr. Kilborn of Blue Shield reporting on the action of the board concerning the association's requesting financial assistance was read and by consent this letter is to be referred to the Council.

A letter from Dr. Norman R. Booher to President-elect, Doctor Corcoran, concerning the Indiana State Medical Association inviting the Midwestern Regional Conference of the AMA Council on Voluntary Health Agencies to meet in Indianapolis in the fall of 1969 was discussed and on motion of Drs. Steen and Kintner, such an invitation is to be extended.

A letter from the President-elect, Dr. Corcoran, concerning an organization called the National Association of Foreign Medical Graduates was reviewed together with the contents of a telephone message from Mr. Pickering, secretary of the Allen County Medical Society.

A letter from the Federation of State Medical Boards was reviewed and on motion of Drs. Steen and Corcoran, this matter is to be referred to the association legal counsel for study and opinion.

Memo from the AMA listing vacancies which had occurred on various councils and committees of the AMA was read and this information is to be referred to the Council.

The secretary reported he had obtained several more laws on making the use of blood a service and not a sale. This was reported for the information of the committee.

The famous Darling case which has the effect of stripping charitable immunity from the hospitals was reviewed for the information of the committee.

Annual Convention

The annual convention program was reviewed and no changes were made.

Application of a physician for a scientific exhibit, which had been referred to the Executive Committee by the Scientific Exhibit Committee was reviewed and on motion of Dr. Scamahorn and taken by consent, it was voted not to accept this exhibit for the scientific area.

The request of Dr. Brown for a meeting of the small county society delegates which he proposed to hold at 1:30 p.m. on Thursday afternoon, October 17th, was presented and it was pointed out that this would conflict with the General Meeting. Dr. Brown is to be requested to hold this meeting on Thursday morning prior to the Socio-Economic Conference.

The Executive Committee approved the suggestion that Dr. J. W. Bowers of Fort Wayne be responsible for the Fifty-Year Club reception on Wednesday, October 16th.

A letter from the Mental Health Association concerning the time to make the award for the Physician of the Year in Mental Health was reviewed and by consent they are to be informed this may be done at the time of the President's Annual Dinner on Wednesday evening, October 16th.

A letter from Dr. Erwin Witkin of the Department of HEW was read and it was taken by consent that Dr. Witkin be invited to sponsor an exhibit at the Fort Wayne meeting.

A letter from Dr. Charles Aust, chairman of Convention Arrangements, was read and by consent it was agreed that Dr. Frank Land would be requested to address the opening meeting of the House of Delegates.

A contract for the use of the facilities of Cutter's Chalet for the Fifty-Year Club reception, the President's Reception, and the President's Dinner, was approved on motion of Dr. Steen and taken by consent.

The contract with The Lantern for their facilities for the entertainment program Thursday night, October 17th, was reviewed and on motion of Dr. Steen and taken by consent, this was approved and the secretary instructed to sign the contract.

The secretary read the proposal concerning a paging system for use during the convention in Fort Wayne and by consent it was agreed that in addition to the staff that this system should be available to the president, the president-elect, and the chairman of the Council.

A physicians' wives entertainment program on Thursday was discussed and the secretary was instructed to check with Mrs. Senseny and make inquiry as to the type of budget she felt would be necessary to conduct this program.

The secretary reported that the committee had accepted the offer of Indiana University to conduct a closed circuit TV program Wednesday morning during the same period of time as had been scheduled for the orientation session. By consent, it was agreed that the orientation meeting would be moved to the second floor of the Scottish Rite building and the TV program would be given in the room normally used for the other scientific sessions, off the Exhibit Hall in the basement area.

The location for the Socio-Economic meeting was discussed and the secretary informed the committee of his conference with Mr. Pickering concerning possible attendance of people in Fort Wayne for this session. It was agreed that the meeting would be scheduled for the room off the exhibit hall and if the attendance was indicated to be more than this room would hold, then it would be moved to the theatre in the Scottish Rite building.

New Business

A matter of meeting with the AMA delegates, the activities of the Future Planning Committee and expenses of officers and delegates was discussed. No definite action was taken.

The Journal

It was suggested that perhaps the editor of *The Journal* might like to write an article which would create a desire on the part of the members to express their views on revising the abortion laws in the state of Indiana.

Future Meetings

The Congress on Occupational Health will meet September 30-October 1 in New York. The secretary reported Dr. Emmett B. Lamb had planned to attend this meeting at his expense and desired to be named the representative of the Indiana State Medical Association. This was approved on motion of Dr. Kintner and taken by consent.

The AMA Fourth National Congress on Quackery will be held in Chicago October 2-3 and it was suggested that this matter be discussed with Dr. Bowen and perhaps some member of the House of Representatives together with Senator Bainbridge might be sent at association expense to this meeting.

The AMA Congress on Medical Ethics will meet in Chicago on October 5-6 and it was decided that no representative will be sent to this meeting.

Regional meetings on Health Care Costs will be held and it was decided that no representative would be sent.

A notice of the Hearings on Nursing Homes was reviewed and by consent no representative is to be sent.

The AMA Conference on Continuing Medical Education is to be held in Chicago November 12-14 and this was deferred until the September meeting.

There being no further business, the committee adjourned to meet again at 12:00 Noon Thursday, September 19, 1968.

AMA
22ND CLINICAL CONVENTION
MIAMI BEACH
DECEMBER 1-4, 1968 · CONVENTION HALL

. . . the American "Riviera." Where glittering luxury hotels tower above glamorous Collins Avenue; and medicine, sea and sunshine mix in a delightful subtropical setting.

Register now, and be on hand for the world's largest winter medical meeting—the AMA's 22nd Clinical Convention. At this midwinter "summer" session in medicine there will be Three Postgraduate Courses: Fluid and Electrolyte Balance, Diabetes, and Hyperthyroidism in the Elderly Patient • 17 Scientific Sessions • Breakfast Roundtable Conferences • Color Television • and Medical Motion Pictures. The modern, air-conditioned Convention Hall will house hundreds of scientific and industrial exhibits to show you the very latest in equipment, services and drugs.

Plan now to join your colleagues in Miami Beach. Be sure to look for the complete scientific program, plus forms for advance registration and hotel accommodations in the October 21st issue of JAMA.

COMMERCIAL ANNOUNCEMENTS

BUY AND TRY: Wye Plantotion Aberdeen-Angus frozen semen from Advonced Register P.R.I. sires officiolly gaining over four pounds per doy or whose 365-day weights ore obove 1,200 pounds. (Performonce tested sires olwoys for sole.) WYE PLANTATION, Queenstown, Moryland 21658. Telephones: 301-827-7166 or 301-827-7160.

WANTED: In a college community, an associate or partner for a large medical proctice. No surgery or OB. General practice can be done if desired. X-ray and laboratory facilities in the office. If desired, will consider sale. Write Box 344, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

PEDIATRICIAN: Salary to $18,000 first year, partnership with 3 general practitioners second year. Midwest university town; 600-bed hospital; intern program. Contact L. L. Wince, M.D., Children's Clinic, 806 W. Jackson St., Muncie, Ind. 47305.

FOR SALE: The unexpected death on August 18 of Dr. Wendell Stover, Boonville, makes available his practice. Recently remodeled office located on public square in county seot town of 6,000 population. Equipment and records available. Building may be purchased or lease arranged. Contact Mrs. Wendell Stover, 20 Lakeshore Dr. (phone 812-897-2481) or Don Julian, 204 S. Third St. (phone 812-897-0842).

EMERGENCY ROOM PHYSICIAN: Excellent opportunity for young physician interested in full-time practice of emergency room care. Join a physician group responsible for the emergency service of two major Cincinnati hospitals. Remuneration on o fee-for-service basis with guaranteed minimum. Must have or be eligible for Ohio license. Send resume to P. O. Box 36163, Cincinnati, Ohio 45236.

WANTED: G. P. for New Castle; replacement in four-man group. Starting guarantee at least $35,000 first year; then partnership with increase. Rotating schedule; on duty less than 50% of the time. Call (317) 529-6250, Henry County Clinic.

WANTED: Quiet, progressive community of 7,000 in East Central Indiana needs more general practitioners. Within 25 minutes of three hospitals. Three doctors in area now. Excellent educational system. Within 1½ hours of Indianapolis, Dayton, Cincinnati. Moy we send you more information? Community Medical Services Council, Box 222, Cambridge City, Indiana 47327.

PSYCHIATRIC RESIDENCIES: Starting July 1969. Approved training in a mental institution with State of Michigan, Department of Mental Health. Three and five year programs available. Salary $9,876-$11,233 and $11,254-$21,381. NIMH-GP stipends $12,000. Located in Michigan's serene, scenic recreation area on Grand Traverse Bay. For additional information, contact Dr. Paul Kauffman, Training Director, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

PUBLIC HEALTH PHYSICIANS: Positions available in local health departments for medical doctors with medical experience and training in public health. Salary range $20,000 to $25,000. Contact Mr. Roy Manty, Chief, Division of Local Health Administration, Department of Public Health, 3500 North Logan, Lansing, Michigan 48914. An equal opportunity employer.

Immediate employment
opportunity

PHYSICIAN needed for occupational health service. Career opportunity. Previous industrial experience not required. Plant has comprehensive medical program of pre-employment, health maintenance, and emergency room care. Forty hour week. Retired physician will be considered. Reply to Box 355, The Journal, ISMA, 3935 N. Meridian Street, Indianapolis, Indiana 46208.

AN EQUAL OPPORTUNITY EMPLOYER

NINETEEN-MAN Wisconsin group located in college community of 40,000 with excellent hospital facilities is seeking additional associates in the following areas:

1. Internal Medicine
2. Urology
3. General Practice
4. Pediatrics

For further information, please contact D. R. Griffith, M.D., Midelfart Clinic, Eau Claire, Wis. 54701.

NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

Charges for commercial announcements are:

First four lines: $3.00
each additional line: 50¢

Send cash with order. Average count: seven words to the line.

DEADLINE: Fifth day of month PRECEDING month of issue.

ADVERTISERS IN THIS ISSUE

October 1968 Volume 61 No. 10

Associated Credit Bureaus of Indiana 1445
Burroughs Wellcome & Co., Inc. 1385
Breon Laboratories, Inc. 1492
Brown Pharmaceutical Co. 1493
Coca-Cola Company 1452
Dairy Councils of Indiana .....2nd Cover
Dow Chemical Company, The 1383
Geigy Pharmaceuticals ..1386-90, 1408-10, 1448-1450
Glenbrook Laboratories 1369
Hanger, J. E., Inc. 1484
Harding Hospital 1487
Heid's Shoe Store 1488
Hynson, Westcott & Dunning, Inc. 1365
Indiana Medical Bureau 1491
Lederle Laboratories 1367, 1399-1402, 1453, 1481, 1489
Lilly, Eli & Company 1374-75, 1394, 1421
Medical Protective Co. of Ft. Wayne 1495
Mutual Medical Insurance, Inc. 1413
National Drug Company 1377
Parke, Davis & Company 1439, 145
Pitman Moore Company 1378-7
Poythress, Wm. P. & Co., Inc. 148
Professional Life & Casualty Co. 1464-6
Robins, A. H. Company, Inc. 1373 1442, 1459-1461, 148
Roche Laboratories .....4th Cover, 143
Roerig, J. B. & Co. 1482-8
Rorer, William H., Inc. 1407, 149
Sandoz Pharmaceuticals 142
Searle, G. D. & Co. 1440-4
Smith Kline & French Laboratories .....3rd Cove
Strasenburgh Laboratories 141
Stuart Company, The 137
Voyager 1000 146
Wabash Valley Hospital 141
Warner-Chilcott Laboratories 137
Warren-Teed Pharmaceuticals 1414-1
Winthrop Laboratories 142

In accepting advertising for publication, *The Journal* has exercised reasonable precaution to insure that only reputable factual advertisements are included. However, we do not have facilities to make any comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services, and medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertiser only. Neither sanction nor endorsement of such is warranted. stated, or implied by the association.

Through these doors pass the world's best excuses for not using safety belts.

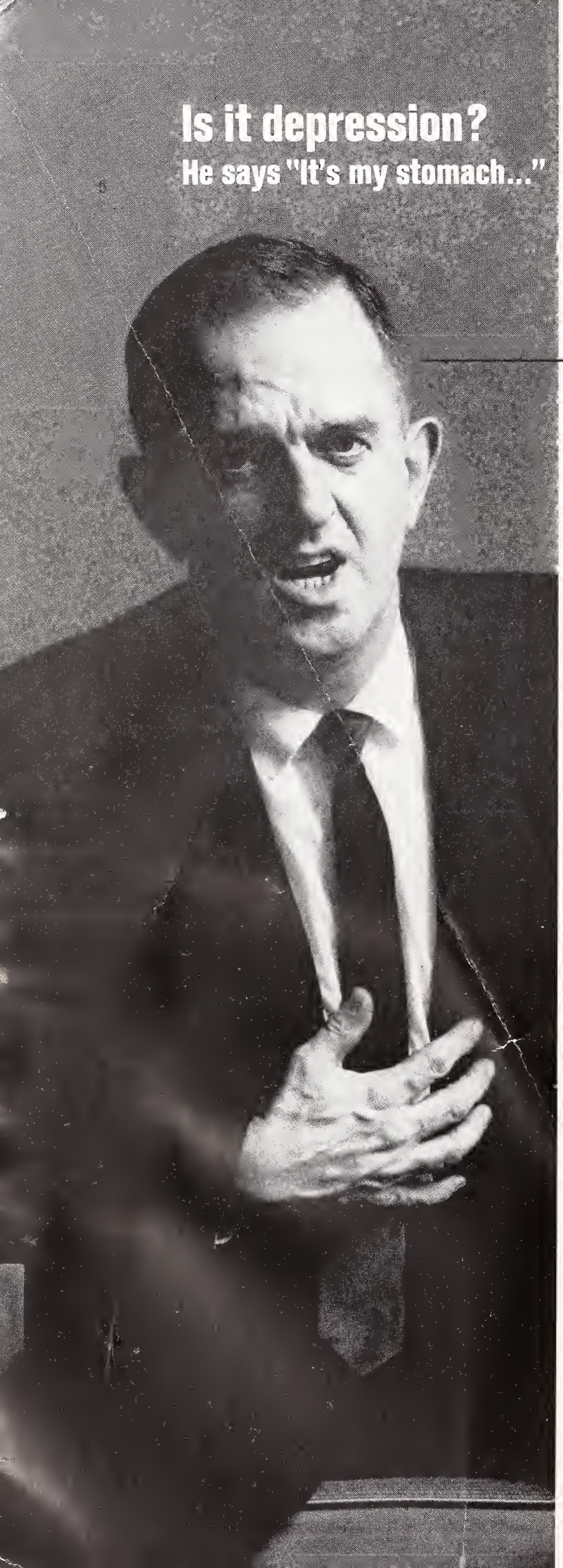
ndiana state medical association.
Journal.

J-O-P
Univ. Of Calif
Med Ctr Library
Acquisitions Dept
San Francisco Calif 94122
12-68

U.C. MEDICAL CENTER LIBRARY
DEC 4 1968
San Francisco 22,

The JOURNAL
OF THE INDIANA STATE MEDICAL ASSOCIATION
Indianapolis, Indiana

November, 1968 Vol. 61 • No. 11



Is it depression?

He says "It's my stomach..."

...but his other symptoms:

functional somatic complaints, anxiety, insomnia, anorexia, feelings of guilt

strongly suggest an underlying depression.

---

when the diagnosis is depression

ELAVIL® HCl (AMITRIPTYLINE HCl | MSD)

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.

MERCK SHARP & DOHME Division of Merck & Co Inc West Point Pa 1948

WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

Lutrexin®

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

IN THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF PREMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION

- LUTREXIN, the non-steroid "uterine relaxing factor" has been found to be useful by many clinicians in controlling abnormal uterine activity.
- Literature on indications and dosage available on request.
- No side effects have been reported, even when massive doses (25 tablets per day) were administered.
- Supplied in bottles of twenty-five 3,000 unit tablets.

(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

HYNSON, WESTCOTT & DUNNING, INC. BALTIMORE, MARYLAND 21201

(LTR23)

NOVEMBER 1968

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Office of Publication

3935 N. Meridian, Indianapolis, Indiana 46208

Contents

SCIENTIFIC

The Evaluation of the Cardiopulmonary Patient for Air Travel, Robert B. Stonehill, M.D., Raymond M. Murray, M.D., Indianapolis 1531

Cardiogenic Shock in Acute Myocardial Infarction, A. D. Dennison, Jr., M.D., Milligan, Tenn. 1537

Some Contributions of Communication Theory to Psychotherapy, James M. Donahue, M.D., Indianapolis 1540

Electrocardiogram of the Month: Nonparoxysmal Ventricular Tachycardia, Charles Fisch, M.D., Indianapolis 1543

X-Ray Conference: Dissecting Aneurysm of the Descending Thoracic Aorta, Erich K. Lang, M.D., Shreveport, La. 1544

Fractures and Orthopedic Problems: Carpal Tunnel Syndrome, Failure of Surgery, William A. Stark, M.D., Michigan City 1547

Path-Finder: Bone Marrow Examinations: Why, When and How?, Leon L. Blum, M.D., Terre Haute 1551

EDITORIALS

New Method Tried in Personal Injury Suits 1554

PMA Comments on Second Report of HEW Task Force 1554

Editorial Notes 1555

SPECIAL FEATURES

Tax Status of Partnerships Under the Indiana Adjusted Gross Income Tax Act 1534

P. J. V. Corcoran, M.D., President, 1968-1969 1556

The Social Security Disability Program, E. B. Haggard, M.D., Indianapolis 1564

The New State Board Examination, Merritt O. Alcorn, M.D., Madison 1566

REGULAR FEATURES

What's New? 1513

Month in Washington 1516

Fourth Estate 1527

From The Journal 50 Years Ago 1542

President's Page 1558

The Woman's Auxiliary Reports to ISMA 1563

Gleaned from the British Medical Journal, Jack W. Hickman, M.D., Indianapolis .. 1573

Medicine At Law 1574

What Is the Blue Shield "Usual and Customary" Program? (One of a Series) 1580

Medical Panorama: Generic Prescription Writing, A. W. Cavins, M.D., Terre Haute 1582

Board of Health Report 1584

Abstracts, Book Reviews 1585

News Notes 1594

Annual Meeting Dates of Professional Medical and Allied Organizations 1603

County, District News 1604

Future Meetings, Seminars, Courses 1605

BUSINESS

Executive Committee: Sept. 19, 1968 1608

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1801 North Illinois Street, Indianapolis 46202. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

Representative for national advertising is the State Medical Journal Advertising Bureau, 515 N. Dearborn St., Chicago, Il

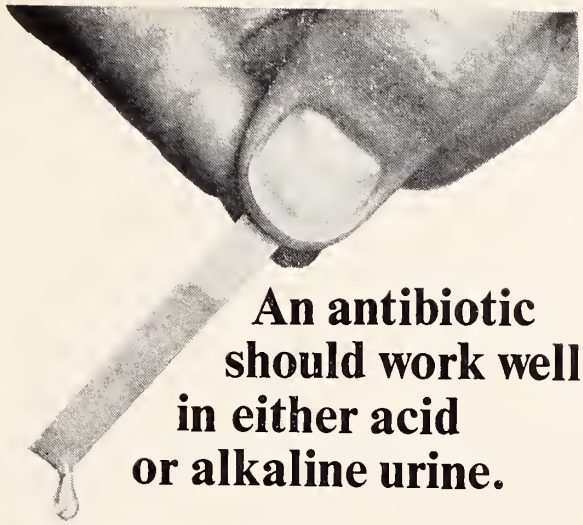
Entered as second class matter January 25, 1933, at the Postoffice at Indianapolis, Indiana. Copyright 1968 by the Indiana State Medical Association. Published monthly at 3935 N. Meridian, Indianapolis 46208.

Second-class postage paid at Indianapolis, Indiana and at additional mailing office.

All issues of 1967 and subsequently may be obtained on microfilm. Address The Journal for details.

About Our Cover

on page 1552.



An antibiotic should work well in either acid or alkaline urine.

It isn't always necessary to adjust urinary pH in treating G.U. infections.

Not when the causative organism is a strain sensitive to DECLOMYCIN® Demethylchlortetracycline, as is often the case.

DECLOMYCIN remains stable and active in either acid or alkaline urine. So there's no need to acidify the urine to keep the antibiotic at work.

Why match the urine to the antibiotic...when you can match the antibiotic to the urine...by prescribing DECLOMYCIN. A b.i.d. dosage makes therapy convenient for your patient.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system – anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin – maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney – rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions–urticaria, angioneurotic edema, anaphylaxis. Teeth – dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; Tablets: film coated – 300 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

355-8

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545

ANNUAL CONVENTION—OCTOBER 13-16, 1969—INDIANAPOLIS

OFFICERS FOR 1968-69

President—Patrick J. V. Corcoran, 3700 Bellemeade, Evansville 47715.

President-Elect—Lowell H. Steen, 2450 169th St., Hammond 46323.

Treasurer—Lester H. Hoyt, M.D., Methodist Hospital, Indianapolis 46202.

Assistant Treasurer—Malcolm O. Scamahorn, Pittsboro 46167.

Executive Secretary—Mr. James A. Waggener, 3935 N. Meridian, Indianapolis 46208.

TRUSTEES

District	Term Expires
1—Gilbert M. Wilhelmus, Evansville	Oct. 1971
2—Joe Dukes, Dugger	Oct. 1969
3—Donald M. Kerr, Bedford	Oct. 1970
4—Robert M. Reid, Columbus	Oct. 1971
5—Wilbert McIntosh, Riley	Oct. 1969
6—Stephen D. Smith, Knightstown	Oct. 1970
7—James H. Gosman, Indianapolis	Oct. 1971
8—Donald R. Taylor, Muncie (Chairman)	Oct. 1969
9—Peter R. Petrich, Attica	Oct. 1970
10—Vincent J. Santare, Munster	Oct. 1971
11—Lowell Hillis, Logansport	Oct. 1969
12—William R. Clark, Fort Wayne	Oct. 1970
13—Otis R. Bowen, Bremen	Oct. 1971

ALTERNATES

District	Term Expires
1—Eugene Austin, Evansville	1970
2—Betty Dukes, Dugger	1971
3—Elmer L. Wallace, New Albany	1971
4—Jack E. Shields, Brownstown	1970
5—Cleon M. Schauwecker, Greencastle	1970
6—Frank Green, Rushville	1969
7—John O. Butler, Indianapolis	1969
8—Paul Sparks, Winchester	1970
9—Lindley Wagner, Lafayette	1971
10—Charles T. Disney, Gary	1969
11—James A. Harshman, Kokomo	1971
12—Frederic L. Schoen, Fort Wayne	1971
13—George B. Gattman, Elkhart	1970

SECTION OFFICERS 1968-69

Section on Surgery:
Chairman—Henry Larzelere, Marion
Vice-chairman—Austin Gardner, Indianapolis
Secretary—Robert Rang, Washington

Section on Internal Medicine:
Chairman—Louis Sandock, South Bend
Vice-chairman—Evart M. Beck, Indianapolis
Secretary—Robert L. Rudesill, Indianapolis

Section on Ophthalmology and Otolaryngology:
Chairman—David E. Brown, Indianapolis
Vice-chairman—Kenneth F. Isenogle, Fort Wayne
Secretary—George A. Clark, Indianapolis

Section on Anesthesiology:
Chairman—Robert W. Vermilya, Lafayette
Vice-chairman—William M. Sholty, Lafayette
Secretary—Adolph P. Walker, East Chicago

Section on General Practice:
Chairman—Robert W. Mouser, Indianapolis
Vice-chairman—Richard Juergens, Fort Wayne
Secretary—Robert Acher, Greensburg

Section on Obstetrics and Gynecology:
Chairman—Tom W. Wachob, Jr., Kokomo
Vice-chairman—Charles R. Echt, Indianapolis
Secretary—Barton T. Smith, Marion

Section on Public Health and Preventive Medicine:
Chairman—Bertram F. Duckwall, Terre Haute
Vice-chairman—
Secretary—Louis E. How, South Bend

Section on Radiology:
Chairman—John A. Robb, Indianapolis
Vice-chairman—Robert E. Beck, Evansville
Secretary—Dale B. Parshall, Elkhart

Section on Nervous and Mental Diseases:
Chairman—Robert O. Bill, Indianapolis
Vice-chairman—Richard L. Shriner, South Bend
Secretary—Wesley A. Kissel, Indianapolis

Section on Pathology:
Chairman—Robert J. Frost, Michigan City
Vice-chairman—
Secretary—Robert L. Costin, Indianapolis

Section on Pediatrics:
Chairman—Roland E. Miller, Lafayette
Vice-chairman—Gustaf W. Erickson, South Bend
Secretary—Morris Green, Indianapolis

Section on Directors of Medical Education:
Chairman—Donald T. Olson, South Bend
Vice-chairman and Secretary—Franklin A. Bryan, Fort Wayne

DELEGATES TO THE AMA

Terms expire December 31, 1969:

Delegates	Alternates
Guy A. Owsley Hartford City	Maurice E. Glock Fort Wayne
Jack E. Shields Brownstown	Dwight W. Schuster Indianapolis

Terms expire December 31, 1970:

Delegates	Alternates
Don E. Wood Indianapolis	James A. Harshman Kokomo
Eugene F. Senseny Fort Wayne	Eugene S. Rifner Van Buren
Frank H. Green Rushville	Kenneth O. Neumann Lafayette

Sources of Sinus Headache

Sinus headache is often a reflection of congestion in the nasal mucosa. The pain that results in the various regions of the head may help in determining the particular structure(s) responsible. The proved formula of Sinutab which provides triple action — analgesic, decongestant and antihistaminic — is specifically designed for the symptomatic relief of sinus headache and nasal congestion.

INDICATIONS: Sinutab is indicated for the symptomatic relief of headache, facial pain, malaise, fever, nasal and sinus congestion often associated with acute and chronic sinusitis, allergic rhinitis, vasomotor rhinitis, influenza, and the common cold.

ADVERSE REACTIONS: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

PRECAUTIONS: Instruct patients not to drive or operate machinery if drowsiness occurs. Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

DOSAGE: Adults — 2 tablets every 4 hours.
Children (6-12 years) — ½ the adult dose.

Each tablet contains 150 mg. acetaminophen, 150 mg. phenacetin, 25 mg. phenylpropanolamine HCl, and 22 mg. phenyltoloxamine citrate.

Source of Symptomatic Relief

Sinutab® | 2 tabs. q.4h.

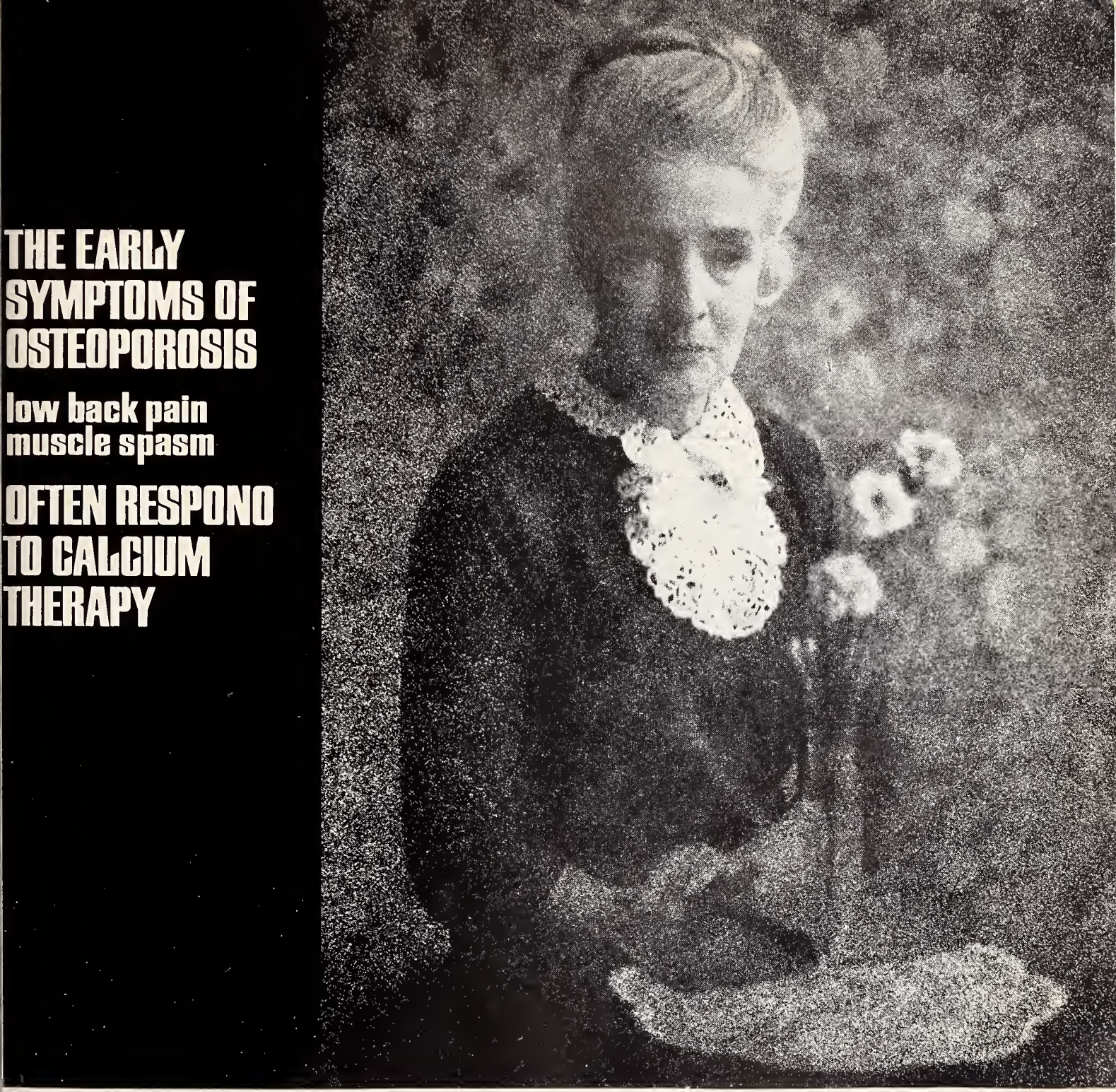
WC

WARNER-CHILCOTT

MORRIS PLAINS, N.J.

COUNTY MEDICAL SOCIETY DIRECTORY

COUNTY	PRESIDENT	SECRETARY
Adams	Arthur H. Girod, Decatur	Harold F. Zwick, 227 S. Second St., Decatur
Allen (Fort Wayne)	Frederic L. Schoen, Fort Wayne	Eugene E. Schmidt, Suite 725, Indiana Bank Bldg., Fort Wayne
		Mr. Larry L. Pickering, Exec. Secy., 212 Med. Ctr. Bldg., Fort Wayne
Bartholomew-Brown	Harold W. Richmond, Columbus	C. David Ryan, 2600 Sandcrest Blvd., Columbus
Benton	A. L. Coddens, Earl Park	D. L. McKinney, Box 398, Otterbein
Boone	James R. McAfee, Lebanon	Katherine A. Jackson, 95 E. Oak St., Zionsville
Carroll	Marilyn L. Wagoner, Burlington	Robert Seese, 101 W. North St., Delphi
Cass	Joseph S. Bean, Logansport	Edward L. TerBush, 216 Ninth Street, Logansport
Clark	Robert K. McKechnie, Jeffersonville	Hassi Shina, Charlestown
Clay	J. Frank Maurer, Brazil	Forrest R. Buell, 314 Lankford St., Clay City
Clinton	Bruce A. Work, Frankfort	George K. Hammersley, 361 E. Clinton St., Frankfort
Daviess-Martin	A. G. Blazey, Washington	Hamlin B. Lindsay, 511 E. Main St., Washington
Dearborn-Ohio	Fred D. Houston, Lawrenceburg	Leslie M. Baker, 501 Fourth St., Aurora
Decatur	Dale D. Dickson, Greensburg	Arnold D. Ducanes, 215 N. Franklin St., Greensburg
DeKalb	John C. Harvey, Auburn	C. Bishop Hathaway, 209 N. Jackson St., Auburn
Delaware-Blackford	Glynn A. Rivers, Muncie	Richard N. Philbert, 2810 Ethel Ave., Muncie
Dubois	John P. Salb, Jasper	Edward Ploetner, 111-115 Central Bldg., Jasper
Elkhart	Philip G. Bowser, Goshen	Page E. Spray, 320 W. High St., Elkhart
Fayette-Franklin	B. W. Sanders, Connersville	J. L. Steinem, 818 Grand Ave., Connersville
Floyd	William F. Ruoff, New Albany	Daniel H. Cannon, 1201 E. Spring St., New Albany
Fountain-Warren	Max N. Hoffman, Covington	Theodore Person, 601 N. Mill St., Veedersburg
Fulton	Joseph D. Richardson, Rochester	r. Richard Walton, 116 W. 9th St., Rochester
Gibson	William E. Dye, Oakland City	David H. Lindauer, 115 N. Prince St., Princeton
Grant	J. C. Jarrett, Marion	Robert G. Young, 1207 Northwood Ct., Marion
Greene	Robert Moses, Worthington	Harry Rotman, Jasonville
Hamilton	John S. Hash, Noblesville	H. R. Blackburn, Riverview Hospital, Noblesville
Hancock	John J. Farrell, Greenfield	Joseph A. Miller, Oaklandon
Harrison-Crawford	Carl Dillman, Corydon	Richard A. Jordan, Corydon
Hendricks	Eli Coats, Indianapolis	Carl J. Heinlein, 637 E. Main, Danville
Henry	John E. Fisher, New Castle	Phyllis Grant, 3007 S. 14th St., New Castle
Howard	Robert L. Michael, Kokomo	J. F. Doss, 3520 Lafountain, Kokomo
Huntington	Wayne S. Miller, Huntington	Stanton E. Cope, 1022 N. Jefferson St., Huntington
Jackson-Jennings	Kenneth E. Bobb, Seymour	William F. Blaisdell, 207 N. Pine, Seymour
Jasper	Ernest R. Beaver, Rensselaer	Francis E. O'Brien, McKinley and Washington Sts., Rensselaer
Jay	Ralph Steffy, Portland	Elizabeth Tate, 317 S. Main St., Dunkirk
Jefferson-Switzerland	Elton Heaton, Madison	Ott B. McAtee, Madison State Hospital, Madison
Johnson	George Brown, Greenwood	Charles Link, 365 E. Main St., Greenwood
Knox	Charles L. Miller, Vincennes	Daniel J. Combs, 1325 McDowell Rd., Vincennes
Kosciusko	Wymond B. Wilson, Mentone	Arthur L. Moser, 600 Winona, Warsaw
LaGrange	Michael O. Mellinger, LaGrange	Allen S. Martin, Box 3A, Shipshewana
Lake	Seymour W. Shapiro, Gary	Reginald R. Barton, 7737 Forrest Ave., Gary
		Mr. John B. Twyman, Ex. Dir., 4640 W. 5th Ave., Gary
LaPorte	William E. Wolf, LaPorte	James J. J. Sprecher, 1001 Maple Ave., LaPorte
		Mrs. Polly Dent, Exec. Dir., 903 Indiana Ave., LaPorte
Lawrence	George W. Sorrells, Bedford	Reid C. Crosby, 11 Saddler Ct., Bedford
Madison	John R. Wagoner, Anderson	William M. Stinson, 333 Jackson St., Anderson
Marion	Hugh K. Thatcher, Indianapolis	A. Alan Fischer, 3500 Lafayette Rd., Suite 203, Indianapolis
		Mr. Arthur G. Loftin, Exec. Secy., 211 N. Delaware St., Indianapolis
Marshall	James Hampton, Argos	Harry Stoller, 109 N. Walnut St., Plymouth
Miami	Parker W. Snyder, Peru	Gordon S. Crates, Denver
Montgomery	V. G. Viray, Crawfordsville	W. E. Shannon, 408 W. Market St., Crawfordsville
Morgan	George Ostheimer, Martinsville	Maurice A. Turner, 101½ N. Main St., Martinsville
Newton	John Parker, Goodland	Arthur Schoonveld, Brook
Noble	O. Thomas Slough, Kendallville	Joseph Greenlee, Avilla
Orange	Charles X. McCalla, Paoli	Phillip T. Hodgin, Orleans
Owen-Monroe	Brad Bomba, Bloomington	Glen D. Ley, 400 E. Third St., Bloomington
Parke-Vermillion	John Somerville, Clinton	Milton Herzberg, Clinton
Perry	Robert Gilbert, Tell City	Gene E. Ress, 507 Main St., Tell City
Pike	M. H. Omstead, Petersburg	M. H. Omstead, Petersburg
Porter	John E. Read, Chesterton	Milton R. Carlson, 14000 Central, Portage
Posey	Paul Boren, Poseyville	Herman Hirsch, 130 W. 5th St., Mt. Vernon
Pulaski	Henry R. Eshelman, Monterey	E. L. Hollenberg, 613 Tippecanoe Dr., Winamac
Putnam	James B. Johnson, Greencastle	Anne S. Nichols, 707 E. Seminary, Greencastle
Randolph	Howard W. Koch, Winchester	Paul W. Sparks, 214 S. Main St., Winchester
Ripley	Bill E. Freeland, Batesville	William J. Warn, Milan
Rush	Donald I. Dean, Rushville	Charles E. Sheets, Manilla
St. Joseph	Jacob Rosenwasser, Mishawaka	L. F. Sandock, 503 Sherland Bldg., South Bend
		Mr. Harry Davis, Exec. Secy., 106 W. Monroe, South Bend
Scott	Ignacio B. Castro, Shelbyville	Jesus C. Bacala, 69 Wardell St., Scottsburg
Shelby	P. M. Inlow, Shelbyville	R. P. Inlow, 103 W. Washington St., Shelbyville
Spencer	John C. Glackman, Jr., Rockport	Michael O. Monar, Rockport
Starke	Earl Leinbach, Hamlet	W. Allen Palmer, Knox
Steuben	Mary H. Cameron, Angola	Richard W. Artz, 416 E. Maumee St., Angola
Sullivan	M. H. Bedwell, Sullivan	J. S. Brown, Carlisle
Tippecanoe	L. H. Wagner, Lafayette	Chester L. Waits, 49 N. 26th St., Lafayette
Tipton	Robert L. Haller, Kempton	Albert E. Stouder, Kempton
Vanderburgh	Ralph Carlson, Evansville	Mr. Arthur P. Tiernan, Exec. Secy., 109½ S. E. 3rd., Evansville
Vigo	John Freed, Terre Haute	Robert L. Meissel, 920 N. 19th St., Terre Haute
Wabash	Fred C. Poehler, LaFontaine	Frank Smyrniotis, 645 Spring St., Wabash
Warrick	Peter B. Hoover, Boonville	Robert C. Colvin, Newburgh
Washington	Eddie R. Apple, Salem	Truman L. Chastain, 906 W. Mulberry, Salem
Wayne-Union	John Stepleton, Richmond	John Dehner, Reid Memorial Hospital, Richmond
Wells	Charles Caylor, Bluffton	R. D. Willard, R. R. 4, Bluffton
White	W. M. Dickerson, Monticello	M. Ali Jehanyar, 116 N. Illinois, Monticello
Whitley	Verlin P. Huffman, S. Whitley	Thomas Hamilton, 115 S. Main St., Columbia City



THE EARLY SYMPTOMS OF OSTEOPOROSIS

low back pain
muscle spasm

OFTEN RESPOND TO CALCIUM THERAPY

In postmenopausal and geriatric patients, low back pain of unspecified origin may be symptomatic of the early stages of osteoporosis and calcium depletion. Treatment with Calcium-Forte, a form of calcium readily available for absorption, may help to restore a positive calcium balance. In doing so, often it can alleviate the symptoms and help to arrest the progress of osteoporosis by preventing further skeletal damage.

One packet of Calcium-Forte contains the equivalent of 500 mg. elemental calcium, the same amount found in one-half quart of milk.

☐ pleasant tasting ☐ highly concentrated
☐ readily soluble

Indications: As an adjunctive measure for major calcium depletion states, which require elemental intakes higher than normal dietary supplements can provide, such as the initial stages of postmenopausal and senile osteoporosis and advanced osteoporosis; also adjunctively with Vitamin D for the treatment of mild or latent hypocalcemic tetany.

Contraindications: Lithiasis, hypercalcemia, cardiac or renal failure.
Precautions: If the patient has a history of renal disease, administration of Effervescent Calcium Granules should be accompanied by abundant intake of acidulous liquids such as fruit juices to avoid hypercalciuria. Should hypercalciuria occur, dosage should be reduced accordingly. Due consideration should be given to the sodium content of Effervescent Calcium Granules when treating patients requiring low sodium diets.
Side Effects: In high doses may cause indigestion or diarrhea. Constipation may occur occasionally.
Composition: Each packet of orange-flavored Effervescent Calcium Granules contains 2.94 grams of the double salt calcium lactate-gluconate and 0.30 grams of calcium carbonate (also contains 325 milligrams of sodium per packet).

New
CALCIUM-FORTE
(Effervescent Calcium) Granules

SANDOZ PHARMACEUTICALS, HANOVER, N.J. SANDOZ

68-207

ISMA Committees and Commissions for 1967–1968

COMMITTEES

Executive
Ralph V. Everly, Indianapolis, chairman; Burton E. Kintner, Elkhart; P. J. V. Corcoran, Evansville, President; Lowell H. Steen, Hammond, President-Elect; Donald Taylor, Muncie, Chairman of the Board of Trustees; Lester H. Hoyt, Indianapolis, Treasurer; Malcolm O. Scamahorn, Pittsboro, Assistant Treasurer.

Grievance
Philip B. Reed, Indianapolis, chairman; Eugene S. Rifner, Van Buren, vice-chairman; Robert G. Young, Marion, secretary; Kenneth L. Olson, South Bend, Earl W. Mericle, Indianapolis; Richard Bloomer, Rockville; John M. Paris, New Albany; Wilson L. Dalton, Shelbyville; William R. Noe, Bedford.

Student Loan
G. O. Larson, LaPorte; Lester H. Hoyt, Indianapolis; Glenn W. Irwin, Indianapolis; Donald R. Taylor, Muncie; James O. Ritchey, Indianapolis; Lester D. Bibler, Indianapolis; Mr. Robert Robinson, Indianapolis.

Medical-Legal Review
Lall G. Montgomery, Muncie; Truman E. Caylor, Bluffton; E. Rogers Smith, Indianapolis

COMMISSIONS

Aging
George M. Young, Gary, Chairman; A. W. Cavins, Terre Haute, Vice-Chairman; Raymond Duncan, Bedford, Secretary; Bernard B. Rosenblatt, Evansville; R. E. Buckingham, Bloomington; Walter S. Fisher, Columbus; Glen A. Ramsdell, Richmond; John O. Butler, Indianapolis; John Cullison, Muncie; Wallace R. Van Den Bosch, Lafayette; George W. Wagoner, Delphi; Nathan Salon, Fort Wayne; Donald T. Olson, South Bend; Andrew C. Offutt, Indianapolis; Wendell C. Anderson, Indianapolis.

Constitution and Bylaws
Gordon S. Fessler, Rising Sun, Chairman; William M. Sholty, Lafayette, Vice-Chairman; James F. Lewis, Liberty, Secretary; George W. Willison, Evansville; Thomas H. Gootee, Jasper; M. C. Topping, Terre Haute; Joseph F. Ferrara, Franklin; B. D. Wagoner, Union City; Chester L. Waits, Lafayette; O. L. Marks, East Chicago; Richard L. Glendening, Logansport; John S. Farquhar, Fort Wayne; Edwin C. Mueller, La Porte; Burton Kintner, Elkhart.

Convention Arrangements
Charles H. Aust, Fort Wayne, Chairman; Durward W. Paris, Kokomo, Vice-Chairman; William M. Kendrick, Mooresville, Secretary; Richard B. Hovda, Evansville; William F. Howard, Bloomington; Irvin Sonne, New Albany; Merritt O. Alcorn, Madison; John E. Freed, Jr., Terre Haute; John Mader, Richmond; Francis E. Stout, Muncie; Boyd A. Burkhardt, Tipton; John L. Ferry, Whiting; James D. Finfrock, Elkhart; Kenneth Kohlstaedt, Indianapolis; Charles Fisch, Indianapolis.

Governmental Medical Services
Charles Hendrix, Vincennes; Guy H. Waldo, Bedford; Herman Echsner, Columbus; Dick J. Steele, Greencastle; Tom S. Shields, Richmond; Robert P. Scott, Indianapolis; J. F. Hinchman, Parker; Ramon B. Dubois, Lafayette; Edward J. Dierolf, Gary; George D. Buckner, Fort Wayne; D. D. Swihart, Elkhart; Jerome E. Holman, Jr., Indianapolis; Glen V. Ryan, Indianapolis.

Inter-Professional Relations
Fred Flora, Frankfort, Chairman; Virgil E. Angel, Highland, Vice-Chairman; William S. Robertson, Spiceland, Secretary; A. Wayne Ratcliffe, Evansville; Philip R. Karsell, Bloomington; Charles X. McCalla, Paoli; John W. Ripley, Seymour; Richard L. Veach, Bainbridge; Willis W. Stogsdill, Indianapolis; Wendell Covalt, Muncie; H. H. Dunham, Wabash; Pierre C. Talbert, Bluffton; A. Alan Fischer, Indianapolis; Robert G. Husted, Munster.

Legislation
Dwight W. Schuster, Indianapolis, Chairman; Don E. Wood, Indianapolis, Vice-Chairman; Jack W. Hickman, Indianapolis, Secretary; Daniel M. Hare, Evansville; Harold Manifold, Bloomington; Elmer L. Wallace, New Albany; Leslie M. Baker, Aurora; Fred W. Dierdorf, Terre Haute; John Davis, Flat Rock; Guy A. Owsley, Hartford City; Max N. Hoffman, Covington; Daniel Ramker, Hammond; Lester Renbarger, Marion; Eugene F. Senseny, Fort Wayne; Otis R. Bowen, Bremen.

Medical Economics and Insurance
Thomas G. Hamilton, Columbia City, Chairman; Thomas J. Conway, Terre Haute, Vice-Chairman; Chester A. Stayton, Jr., Indianapolis, Secretary; Charles M. Sinn, Evansville; Paul W. Holtzman, Bloomington; Edward J. Ploetner, Jasper; William A. Johnson, North Vernon; David R. Cain, New Castle; James M. Leffel, Indianapolis; Charles E. Geckler, Muncie; Kenneth O. Neumann, Lafayette; A. S. Kobak, Valparaiso; Richard Wagner, Huntington; Jack W. Hannah, Elkhart; William J. Miller, Lafayette.

Medical Education and Licensure
James B. Johnson, Greencastle, Chairman; John L. Cullison, Muncie, Vice-Chairman; Forrest LaFollette, Hammond, Secretary; John Sterne, Evansville; Betty Dukes, Dugger; John M. Paris, New Albany; Richard A. Snapp, Columbus; Frank Coble, Richmond, George T. Lukemeyer, Indianapolis; William Ringer, Williamsport; Leo Radigan, Gary; Lowell J. Hillis, Logansport; Joel Salon, Fort Wayne; Jene R. Bennett, South Bend; Merritt O. Alcorn, Madison; Peter J. Pilecki, Michigan City; Glenn W. Irwin, Jr., Indianapolis.

Public Health
T. O. Middleton, Bloomington, Chairman; Henry G. Nester, Indianapolis, Secretary; Daniel Hare, Evansville; Roy L. Fultz, Salem; R. M. Seibel, Nashville; Cleon M. Schauwecker, Greencastle; Wilson L. Dalton, Shelbyville; Stanley W. Burwell, Muncie; Theodore C. Person, Veedersburg; Gilbert Z. Given, East Chicago; Paul Sparks, Winchester; Theodore J. Smith, Whiting; Bertram Roth, Indianapolis; Charles H. Rushmore, Indianapolis, consultant.

Public Information
Frederic L. Schoen, Fort Wayne, Chairman; William B. Challman, Evansville, Vice-Chairman; William G. Moore, La Porte, Secretary; Louis Blessinger, Corydon; Herman J. Echsner, Columbus; William G. Bannon, Terre Haute; Robert D. Spindler, Shelbyville; Robert W. Harger, Indianapolis; Don W. Boyer, Lebanon; Thomas C. Chael, Munster; Fred C. Poehler, La Fontaine; Louis F. Sandock, South Bend; Loren H. Martin, Indianapolis.

Special Activities
Marvin E. Priddy, Fort Wayne, Chairman; Robert M. Brown, Marion, Vice-Chairman; Norbert M. Welch, Vincennes; Robert O. Zink, Madison; John E. Freed, Jr., Terre Haute; Harold C. Ochsner, Indianapolis; Henry Bibler, Muncie; Clarence G. Kern, Lebanon; Adolph Walker, East Chicago; K. G. Hill, New Castle.

Voluntary Health Agencies
Norman R. Booher, Indianapolis, Chairman; James H. Gosman, Indianapolis, Vice-Chairman; M. O. Scamahorn, Pittsboro, Secretary; Albert Ritz, Evansville; Ed R. Cantwell, Vincennes; T. A. Neathamer, Scottsburg; Harry R. Baxter, Seymour; William G. Bannon, Terre Haute; Wayne Endicott, Greenfield; William A. Karsell, Indianapolis; James S. Fitzpatrick, Portland; Albert E. Applegate, Frankfort; John G. Kolettis, Gary; Lloyd L. Hill, Peru; Richard Willard, Bluffton; Frank McGue, Michigan City.

Future Planning Committee
Earl W. Mericle, Indianapolis, chairman; Maurice E. Glock Fort Wayne; James S. Fitzpatrick, Portland; A. Wayne Ratcliffe, Evansville; Fred S. Carter, LaPorte; William B. Challman, Mount Vernon; James E. Wenger, Nappanee; Charles F. Gillespie, Indianapolis; Leslie M. Baker, Aurora, (Ex-Officio Members)—Patrick J. V. Corcoran, Evansville; G. O. Larson, La Porte; Lowell H. Steen, Whiting; Ralph V. Everly, Indianapolis; Frank B. Ramsey, Indianapolis.

1967-68 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	R. E. Weitzel, Princeton	Fred Smith, Tell City	
2.	Brad Bomba, Bloomington	J. S. Brown, Carlisle	
3.	Daniel H. Cannon, New Albany	Elmer L. Wallace, New Albany	April 2, 1969, New Albany
4.	Bill E. Freeland, Batesville	William J. Warn, Milan	
5.	Jack Somerville, Clinton	Milton Herzberg, Clinton	
6.	Stephen Smith, Knightstown	David Wynegar, Richmond	
7.	John O. Butler, Indianapolis	Donald E. Stephens, Indianapolis	
8.	F. E. Stout, Muncie	Richard N. Philbert, Muncie	June 4, 1969, Muncie
9.	Martin Dickerson, Monticello	M. Ali Jehanyar, Monticello	May 22, 1969, Lafayette
10.	R. J. Doherty, Crown Point	Lambro Dimitroff, Calumet City, Ill.	
11.	John D. Pattison, Marion	Fred Poehler, La Fontaine	Sept., 17, 1969, Marion
12.	Kenneth F. Isenogle, Fort Wayne	John J. Hartman, Angola	May 21, 1969, Fort Wayne
13.	John Kerrigan, Michigan City	John Hildebrand, South Bend	

In peptic ulcer: the antacid puzzle

solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O.K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart

Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

a comprehensive hematinic

Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150	mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin (The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)	7.5	mcg.
Iron, Elemental (as Ferrous Fumarate)	110	mg.
Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

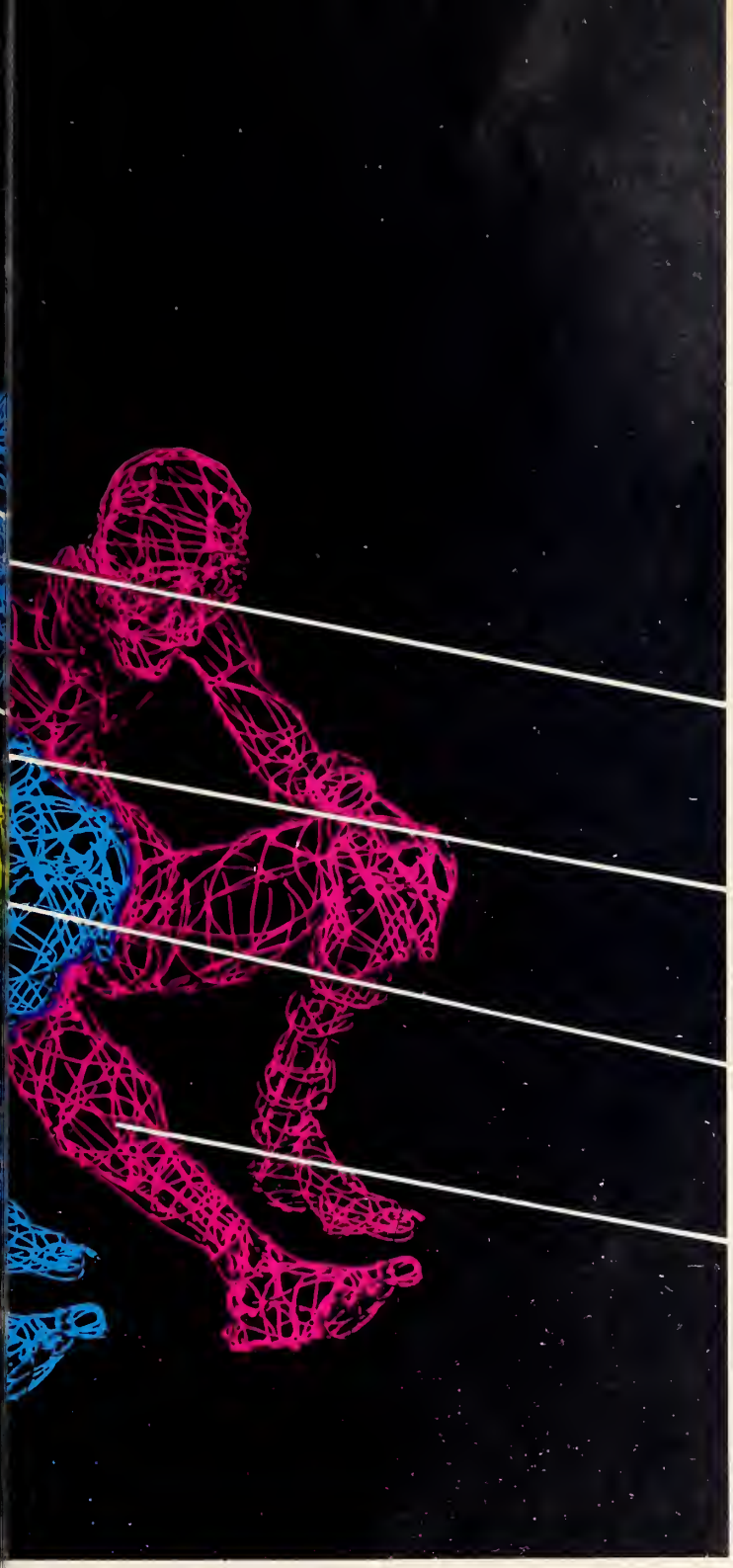
Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropriat investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequat vitamin B_{12} therapy may result in hematologic remission but neu rological progression. Adequate doses of vitamin B_{12} (parentera or oral with potent intrinsic factor as in Trinsicon® [hematini concentrate with intrinsic factor, Lilly]) usually prevent, halt, o improve the neurological changes.

As with all preparations containing intrinsic factor, resistanc may develop in some cases of pernicious anemia to the potentia tion of absorption of physiological doses of vitamin B_{12}. If resist ance occurs, parenteral therapy, or oral therapy with so-calle massive doses of vitamin B_{12}, may be necessary. No single regi men fits all cases, and the status of the patient observed i follow-up is the final criterion for adequacy of therapy. Periodi



You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500. [032568]

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206.

801668

Lilly

"The inconvenience of a cold"

For a cold, NTZ® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTZ is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTZ Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

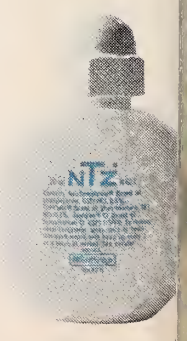
Supplied: NTZ Nasal Spray, plastic squeeze bottles of 20 ml.; NTZ Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

NTZ is more than a simple vasoconstrictor. It contains

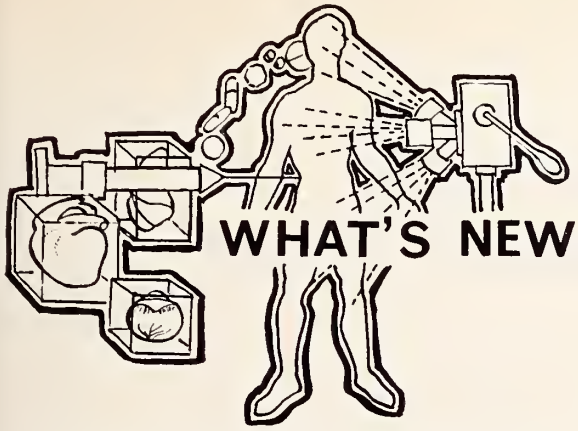
Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



Winthrop Laboratories, New York, N.Y. 10016 Winthrop



WHAT'S NEW?

Record-O-Fone Extended Message System has been installed by the Metropolitan Life Insurance Company to receive and record automatically the phoned medical reports which doctors may make in lieu of time-consuming written reports. It is expected that the system will be much faster and will eliminate difficulties due to illegible handwriting. The system answers the physician's call and instructs him as to procedure prior to his dictation.

* * *

Bennett IPPB therapy and respiration units will have a new ultra-high-efficiency bacteria filter. It will entrap bacteria with an efficiency up to 99.97% from the gases both flowing to the patient and away. It is made of a fibrous medium, is sealed in a stainless steel shell and may be autoclaved repeatedly.

* * *

Syntex has introduced a new oral contraceptive dosage form which is based on the "Pill-a-Day" schedule. Called "Noriday", the new form provides 21 white tablets, each with 1 mg. of norethindrone and 0.05 mg. mestranol, together with seven orange tablets containing inert ingredients, to round out the 28-day schedule. Clinical studies have shown that patients will miss fewer doses if the schedule is continuous, and does not depend upon intermittent dosage.

* * *

Ames has an improved Clinistix Reagent Strip. The new model has a clear resilient plastic handle which makes the strip easier to handle, eliminates drooping and is easier to read, since the color in the test area is contrasted with the clear plastic. They are packaged in glass bottles of 50 strips.

* * *

Parke-Davis is marketing a new product containing enzymes to help clean wound surfaces and an antibiotic to treat infection. Elase-Chloromycetin Ointment contains fibrinolysin and desoxyribonuclease and chloramphenicol for use on surfaces. Elase was originally introduced in 1960 as a powder.

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments, and surgical appliances and book publishers. Each item is published as news and does not necessarily constitute an indorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

THE BETTMANN ARCHIVE

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

"Now that your acne is clearing up nicely, it might be a good idea if you started losing some weight."

Get them while they're easily reversible.

Obesity doesn't happen suddenly. This insidious process has its beginning—and the chances of reversing it are better—during the *first 10 to 15 pounds of weight gain.* When a new dietary pattern must be established, consider the adjunctive use of BAMADEX SEQUELS. Combining the proven *anorexigenic* action of d-amphetamine with the *tranquilizing* effect of meprobamate, BAMADEX SEQUELS controls appetite throughout the day, usually with a single capsule daily.

Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.
Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

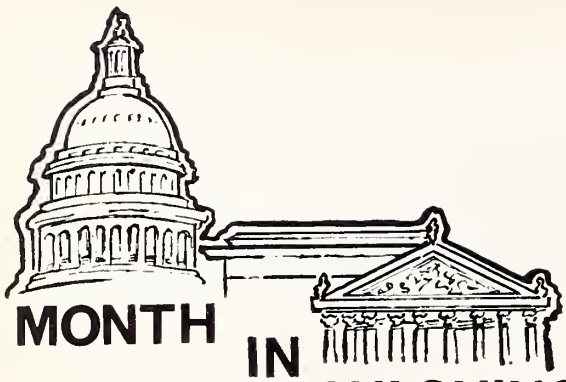
Bamadex® Sequels®

Dextro-Amphetamine Sulfate (15 mg.) with Meprobamate (300 mg.) Sustained Release Capsules

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York

407-8



MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

WASHINGTON, D.C.—The American Medical Association protested strongly against proposed new medicaid regulations affecting payments to physicians and utilization review.

THE PROPOSED regulation on physicians' reasonable charges was described as an anomaly in a protest to the Department of Health, Education and Welfare.

IN THE PROTEST filed with the Department of Health, Education and Welfare, the AMA termed the proposed regulation on physicians' "reasonable" charges as an anomaly because it is based on payments received with no consideration given to the usual and customary fee.

SINCE medicare payments made by the government are 80% of the reasonable charge, this amount could become the maximum of every charge under medicare, the AMA said. Or, were physicians to receive less than full payment and write off losses, the reduced payments could become the basis for the reasonable charge under medicaid.

THE NEW regulation on utilization review would require a state medicaid plan to provide for utilization review of each item of service, including a physician's in his office or in the patient's home. The AMA said it could lead to a set of national standards with authorized treatment for each medical condition limited in a manner set by regulation.

THE AMA SAID it is not opposed to a "claims review" process like that now in operation in many areas or as conducted under medicare. Nor, the AMA added, did it find fault with inquiring into a physician's conduct where fraud is alleged, or where it appears on the basis of medicare claims submitted, that there is reasonable ground for further investigation of a possible fraud.

IN ANOTHER development, the Advisory Commission on Intergovernmental Relations supported a medicaid goal of comprehensive health care for the needy and medically needy by 1975, but proposed changes in financing and operation of the federal-state program.

THE REPORT was directed particularly to "the virtually unmanageable fiscal burden imposed on state and local governments by the program." It urged that consideration be given to "broadening medicaid's financial base through increased involvement of the private sector through an employer-employee contributory health insurance system." If Congress approved this proposal it would be a giant step toward national compulsory government health insurance.

THE COMMISSION rejected proposals to limit federal sharing in medicare and to establish national eligibility standards for beneficiaries.

THE REPORT was made public soon after the Senate voted a $500 million cutback in medicaid funds and when some states already were trimming their medicaid programs because of a financial pinch.

THE COMMISSION recommended that the states "move vigorously to experiment with methods of increasing the efficiency and economy of health services under the medicaid program," including: (1) Reimbursing hospitals contingent on their operating under an acceptable standard of management efficiency, (2) expanding prior authorization for elective surgical procedures, (3) payment for physicians' services on a basis other than usual and customary charges, (4) use of co-payments for the purchase of specified health care services, and (5) improved techniques of utilization review.

THE 26-MEMBER commission is a bipartisan body established by federal law in 1959 to maintain continuing review of the relations among federal, state and local governments. Its membership consists of governors, mayors, county officials, state legislators and representatives of both houses of Congress, the federal executive branch and the general public. The chairman is Farris Bryant, former governor of Florida.

CONGRESS APPROVES EXTENSION OF MEDICAL PROGRAMS

CONGRESS approved a two-year extension of the regional medical programs and a one-year extension of the Hill-Burton program of federal aid for construction of hospitals and other health care facilities.

THE LEGISLATION authorizes appropriation of $65 million in this fiscal year, ending next June 30, and $120 million for the next year for the regional medical programs. The Senate had voted a three-year extension but it was dropped in a House-Senate conference which worked out the compromise.

HOUSE CONFEREES, however, emphasized that "this program, although a newly established one, has already proved its value and should be considered as a permanent program." They said they accepted the two-year extension to give the next Congress an opportunity to review the program.

THE Hill-Burton program was authorized $195 million for hospitals and $100 million for other health care facilities. The conferees abandoned Senate provisions for a new three-year program of federal loans of $200 million a year for hospital modernization and a guaranteed loan program of the same amount with a federal subsidy of interest. These provisions also were left for further consideration by the next Congress.

A TOTAL OF $40 million was authorized for two years for construction and staffing of rehabilitation facilities for narcotics addicts and alcoholics. As a declaration of Congress, the measure states:

"ALCOHOLISM is a major health and social problem afflicting a significant proportion of the public and much more needs to be done by

Continued

Continued

public and private agencies to develop effective prevention and control."

THE PROGRAM of grants for family health service clinics for migratory agricultural workers was extended for two years with $9 million authorized for the current fiscal year and $15 million for the next year.

NATIONAL FAMILY HEALTH WEEK

CONGRESS approved legislation designating Nov. 17-23 as "National Family Health Week." The legislation termed the week "as a means of focusing national attention during the year upon the accomplishments of the American health care system and the central role played by the family physician in the maintenance of superior medical care for Americans of all ages and from all walks of life."

NATIONWIDE PROGRAM FOR AMBULANCE PERSONNEL?

THE COMMITTEE on Emergency Medical Services of the National Research Council has recommended establishment of a nationwide program for the training of ambulance personnel.

THE COMMITTEE PROPOSED guidelines for such training, stating that there is at present "no uniformity in the course of instruction and . . . no generally accepted standards of proficiency to be used by those empowered to certify ambulance personnel."

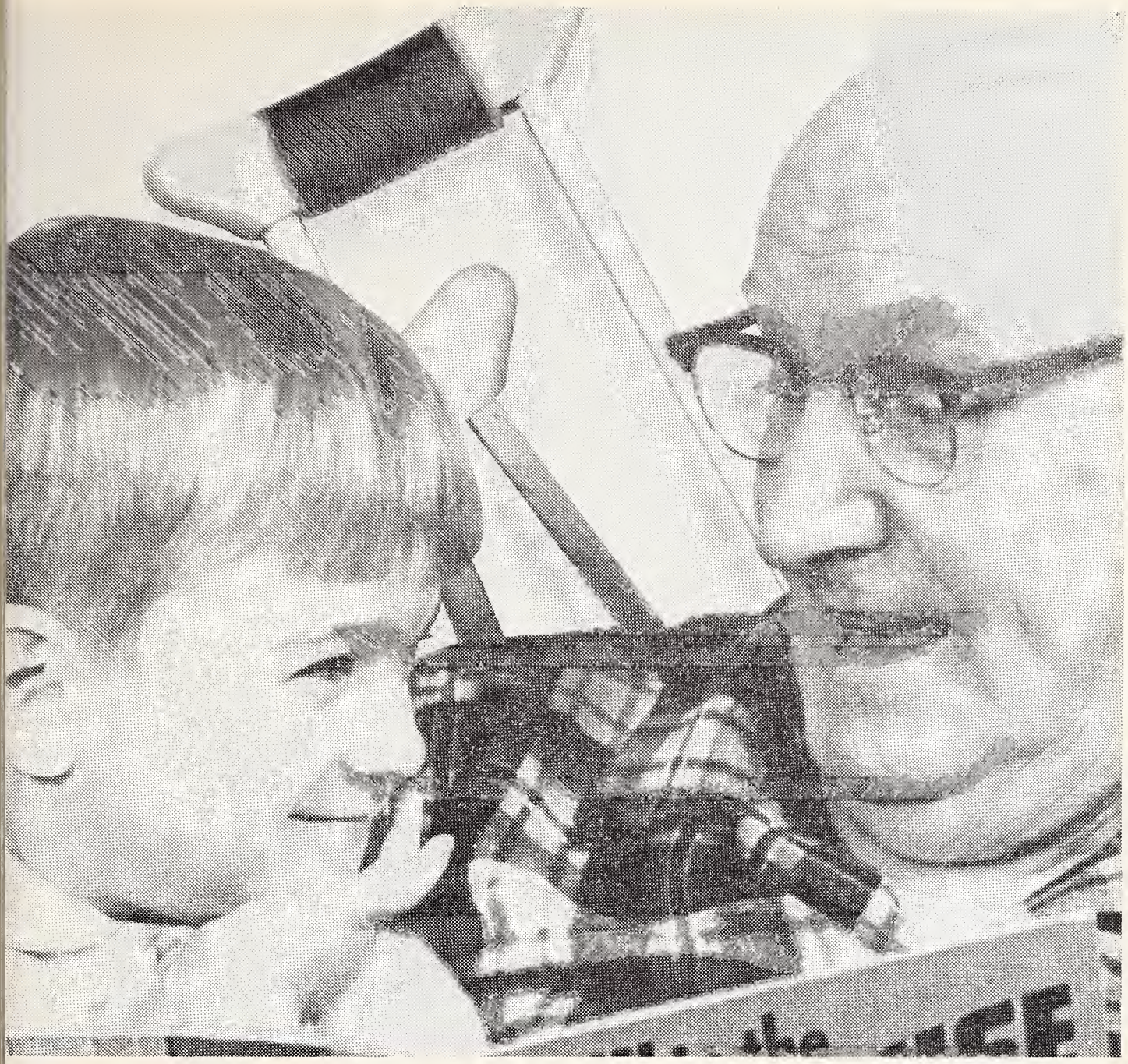
THE COMMITTEE'S recommended guidelines cover: either the standard or advanced first aid courses of the American National Red Cross as a prerequisite, the operation of emergency vehicles, safety precautions at the accident scene, priorities of care, records, the use of communication systems, the use of equipment and supplies, medicolegal problems and rescue procedures.

THE LEVELS of proficiency designed to result from the course proposed in the report are attainable in most areas of the country within a reasonable time, the committee said. However, to realize the greatest life-saving potential, the ambulance attendant of the the future should be trained to the same level as lay assistants in emergency departments or medical corpsmen in combat areas; and, ideally, he should be qualified to carry out, either independently or through voice communication with a physician, such procedures as tracheostomy, defibrillation and mechanical external cardiac compression, the committee said.

TO ATTAIN these goals, the committee said, accredited hospital training programs must be established that will produce professional ambulance attendants and emergency department assistants of the caliber of certified x-ray, laboratory, physical therapy and other accredited medical technicians.

THE AMBULANCE attendant, it added, must be fully engaged in emergency care in an established career pattern that provides attractive compensation, prestige and recognition deserving of his

Continued



Coming home is wonderful

when you have

Blue Cross–Blue Shield

Mutual Hospital Insurance, Inc. Mutual Medical Insurance, Inc.
Home Office: 110 N. Illinois St., Indianapolis, Indiana 46204

If you're over 65 and have Blue Cross–Blue Shield's Medicare Supplement, coming home from the hospital is especially wonderful. That's because the Supplement provides lots of benefits to help fill the gaps in Medicare, and brings you home without a worry about big health care bills. These days—when costs are up for our fine hospital and doctor services—you need Blue Cross–Blue Shield more than ever.

Eligible for Medicare? Then you're eligible for Blue Cross–Blue Shield's Medicare Supplement.

Folks around 65 can get more information about Medicare Supplement by sending name and address to Blue Cross–Blue Shield, 110 N. Illinois Street, Indianapolis.

For just a small monthly fee you can join the more than 200,000 members over 65 who have the Medicare Supplement and the peace of mind that goes with it. They, and persons of all ages say the same thing:

"I don't know what we would have done without Blue Cross–Blue Shield."

(One of a series of ads being run in key Hoosier newspapers)

November 1968

1519

Continued

services as a member of the emergency care team. Where the needs for ambulance services are low so that he is not fully occupied, such as in small communities, he should be an employee of a hospital, where he can maintain his interest and proficiency as an assistant in the emergency department, intensive-care unit or operating room, the committee said.

HIGH INCIDENCE OF RETARDATION AMONG THE POOR

THE PRESIDENT'S Committee on Mental Retardation reported that three-fourths of the nation's six million mentally retarded live in urban ghettos and rural slums and were unwanted, unplanned children.

THE COMMITTEE'S second annual report, entitled "The Edge of Change," dealt with the high incidence of retarded development among the poor, the shortage of manpower to serve the retarded and the low quality of residential care available to most of them.

THE COMMITTEE'S recommendations called for:

—Education and health services for every child from birth.

—An insurance system to give parents a free choice in selecting needed services.

—Development of national accreditation standards for residential facilities for the retarded.

—Voluntary family planning services for all Americans. ◄

A hospital for the diagnosis and treatment of psychiatric illness

WABASH VALLEY HOSPITAL

(a not for profit corporation)

2900 North River Road (State Road 43 north)

West Lafayette, Indiana 47906 Phone 317-463-2555

Active Psychiatric Staff	(Phone)	Robert K. Jones, Ph.D. Clinical Psychologist
W. R. VanDenBosch, M.D.	447-6404	
David L. Evans, M.D.	447-9155	Mrs. Margaret Keedy, A.C.S.W. Psychiatric Social Worker
Joe M. Martin, M.D. Edgar C. Stuntz, M.D.	463-2695	
Limited private practice		Elizabeth J. Snyder, R.N. Director of Nursing Service
John H. Wilms, M.D. F. H. Spurlock, M.D. Alfred R. Heasty, M.D.	749-2441	James Jones, B.P.E. Director of Activity Therapy

Donald R. Kinzer, Hospital Administrator

John Sterzer, Business Manager

Admissions are arranged through referral to any active staff psychiatrist.

All general medical and surgical specialties in the community are available through physicians on the open consulting staff.

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.

The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.

A realistic approach to pain relief

Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

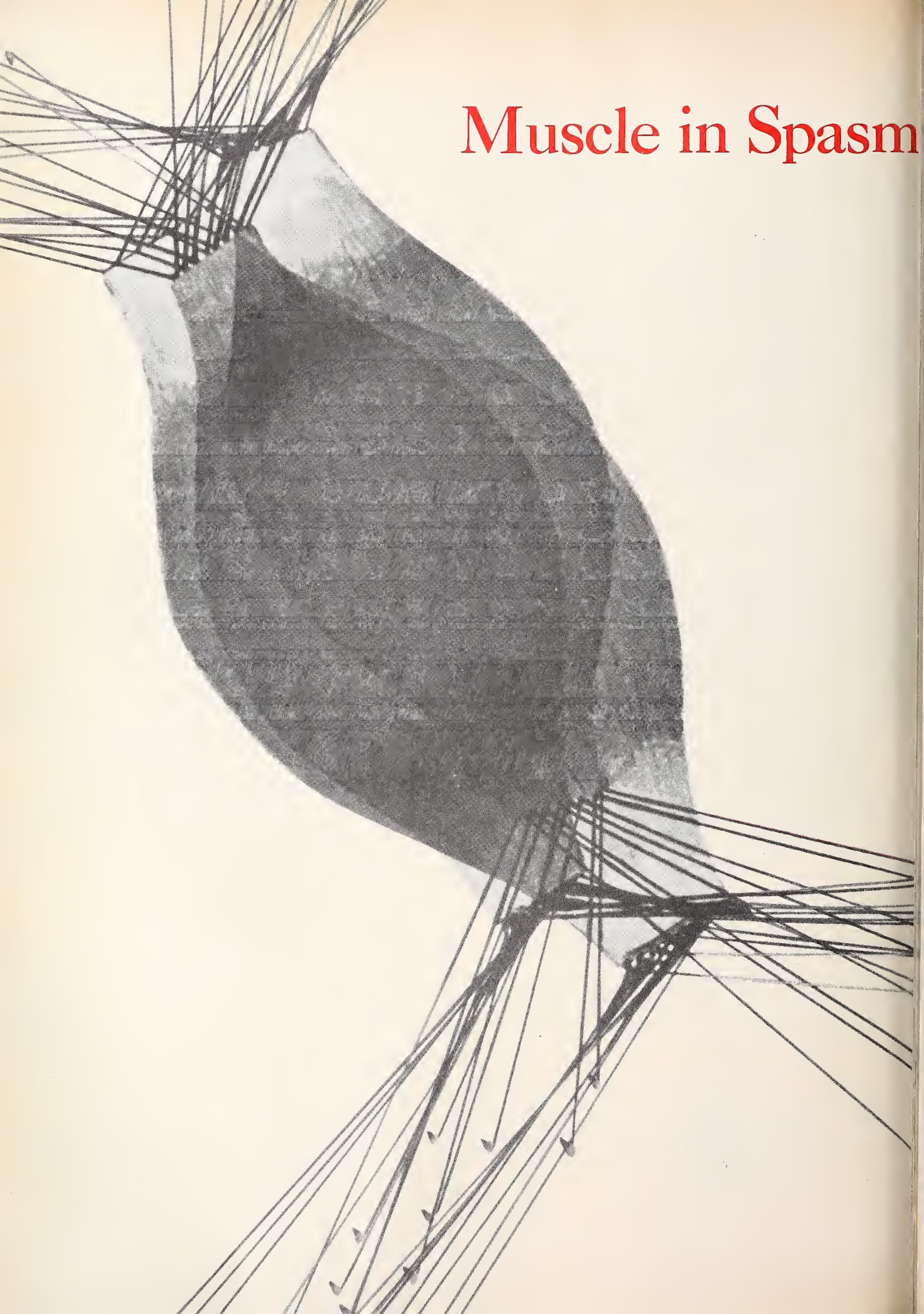
Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.

Muscle in Spasm



and Valium (diazepam)

The ability of Valium to help relieve skeletal muscle spasm—as well as psychic tension—demonstrates its clinical value and versatility.

The muscle-relaxant effect obtained with Valium, used adjunctively with other drugs or physiotherapy, favorably affects the entire cluster of spasm-related symptoms . . . helps accelerate return to normal activity.

When skeletal muscle spasm and psychic tension coexist, the calming effect of Valium is an added therapeutic benefit that contributes to the total management of the patient.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium®(diazepam)
2-mg, 5-mg, 10-mg tablets

ROCHE
Roche®
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

A little

Just one 50 or 100 mg tablet in the morning can work a long diuretic day in edema and hypertension.

HY-6060

Hygroton® can work a long day too

chlorthalidone

That's because of its prolonged action, which usually provides smooth diuretic activity throughout the day. And one-a-day dosage means few tablets to take and few tablets to pay for in the long run.

Hygroton, brand of chlorthalidone, may mean troublesome side effects for certain patients. And you can't prescribe it in cases of demonstrated hypersensitivity to the drug or in severe renal or hepatic diseases.

Before writing it for your patients, please check the Prescribing Information. It's summarized on the next page.

Hygroton

chlorthalidone in edema and hypertension

Geigy

in edema and hypertension

A little Hygroton® can work a long day

chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic diseases.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypotension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

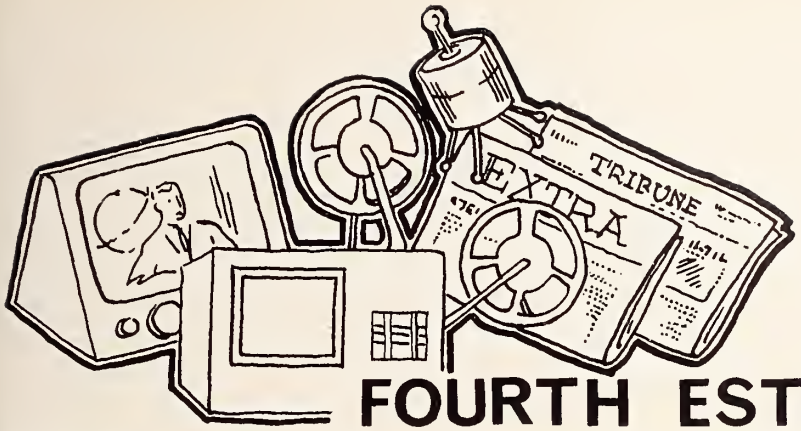
Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.

(B)46-230-E

For full details, please see the complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

H-4060



FOURTH ESTATE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Revisions on the Last Chapter

If you can abide that sort of thing, there is a certain grisly and macabre humor in the current efforts of some segments of the medical profession to redefine death in light of the logistical needs of the heart transplant industry.

As the latest example, we have a "white paper" of life and death, drawn up by pedagogical physicians, surgeons, artists and divines of Harvard University. Their position more or less drops the simple concept of "death" and substitutes for it a condition defined as "irreversible coma," or "brain death," the arrival of which presumably signals the start of work for the excavators and movers.

The committee has established a list of criteria for determining "irreversible coma"—failure to respond to external stimuli, no spontaneous muscular movement for an hour, no groaning, or spontaneous breathing and failure of the patient to breathe spontaneously when a respirator is turned off for a period of three minutes. Apparently the mere fact that the heart was beating as the result of the mechanical respiration of the patient would not constitute "life" as contemplated in the homicide statutes.

Boiling it down to its essence, the committee seems to feel it is more important that electrical brain waves be emanating from the subject's cerebrum than that his heart be beating as the result of the application of an electrical respirator, and so far as we know it is one of the few circumstances in which it is more important to be tuned in than turned on!

But the most frightening paragraph of all is the recommendation of the savants that all of the tests for "irreversible coma" be repeated after a period of 24 hours, just to make sure that the coma has not somehow reversed. We are led to the inescapable conclusion that the only way the subject can be certain he will R.I.P. is to keep breathing.—*Fort Wayne News-Sentinel*, Aug. 7, 1968.

A Life Of Public Service

Dr. Charles W. Meyers, who has announced his retirement after 37 years of service to the hospital which now is Marion County General Hospital and to the Health and Hospital Corporation, has spent virtually all his working years in public service and volunteer civic activity.

His career as a physician and surgeon was shifted almost at its outset into the Army Medical Corps, in which he was thrice decorated for distinguished service in evacuating wounded soldiers from advanced battlefield positions in World War I.

From the war he turned to the medical service of the Veterans Bureau, now the Veterans Administration, becoming a surgeon in Indianapolis.

From that work he moved to City Hospital, now General, as superintendent. One inkling of the measure of his dedication is the fact that he established his residence in the hospital so that he would always be available. He stepped down from the superintendent's post after 21 years, in 1952, and then was a trustee of the newly formed Hospital Corporation, a position he has held since that time.

During these many years he has also found time for countless civic enterprises in the community. As one friend put it, "He was active in everything."

Now 78 years old, Dr. Myers figures it's time for a more restful life. He has well earned it. He has truly given his life to medicine and to serving his fellow men.—*The Indianapolis Star*, Aug. 16, 1968.

Death Claims "Old Doc" at Age 57 —

Boonville's Dr. Stover: Combat Medic, Athlete and Fan

By BILL ROBERTSON

For most of America's millions, this August 21st was not much different from all other August days . . . hot, humid, oppressive, expectant, precious, promising and inexorable.

But for some it was a sad day, too, especially for a man named Vickers . . . and another named

Stireman . . . and another named Schallin . . . wherever they may be.

Out of the misty past they could tell you that they were among the wounded and bleeding who rode back from the fiery skies over Germany on an unforgettable day in 1944 . . . back to the shelter of a U. S. heavy bomber base in Britain where Smoky Stover was waiting for them.

Back home in Indiana he was Dr. Wendell C. Stover, who at the age of 30 was the youngest of seven doctors in Boonville, Ind. But at the age of 33, at an Eighth Air Force base in England during the angry years, they called him Capt. Smoky Stover — philosopher, confidant, flight surgeon and a friend indeed to those who came back each day from the inflamed heavens above Dusseldorf and Limburg and Cologne.

And wherever they are today, Vickers and Stireman and Schallin, Lt. Biddick and radioman Eigers and the other members of the crew of a crippled Flying Fortress that returned safely that day 24 years ago likely remember Capt. Stover as he hurried aboard the big B-17 while the red landing flares were still burning.

He stopped the bleeding, applied a splint to a shattered leg and then watched intently as the wounded men were removed on litters through a window of the plane and rushed to the base hospital.

That's why they would all be shocked today to learn that Smoky Stover is gone. He lies in a flower-covered grave in Maple Grove Cemetery in Boonville — dead at the age of 57, long before he became known as "old Doc Stover" as he once visualized the day to a magazine interviewer.

As flight surgeon on a heavy bomber squadron that trained for overseas duty at Westover Field in Utah, Capt. Stover had to pass the Air Corps "64" flight physical, just as the pilot and gunners did. He also had to complete 60 hours of flying time and completed a course in aviation medicine at Randolph Field in Texas.

He had a reputation as a capable, dedicated flight surgeon with a sense of humor, straightforward and with a built-in refusal to pamper the men in his squadron.

Those who remembered a happier and less combustible era long before Nazi guns turned the world into a maelstrom could tell you that Wendell Stover's first experience as a captain was a lot more fun back in 1927 than it was in 1944.

That was the year that he was captain of the Linton High School basketball team and it was always a matter of historic moment to him that he played in the first basketball game ever played in Central Gym — which is out-living him by a year.

It was also a matter of pride that he was an athlete at the same Linton High School where Elmer Oliphant preceded him by many years. Oliphant, who once scored 60 points in one football game, went ahead to become one of Purdue's most famous sports legends, then became an All-American at the U.S. Military Academy. The athletic field at Linton is named for him.

But back to Central Gym. The first game played in the 41-year-old Evansville hallmark that is doomed to limbo after one more season was on Dec. 10, 1927.

"It was just about the finest place any of us had ever seen." Dr. Stover recalled years later.

There were some 3,000 other folks there who probably thought the same thing. Among them was Arthur L. Trester, austere and implacable head of the IHSAA who was scheduled to deliver the dedicatory address preceding the game but arrived late and spoke at halftime instead.

Central's Norman Buck went down on the opening tipoff and scored the first basket from just behind the foul circle and the Bears went ahead to defeat Linton, 30-24, in a Saturday night "thriller." High scorer for the game was a Linton lad named Rennie, with ten points, but young Stover came up with two field goals and two free throws — which was a good night for a guard back in those conservative days.

It was a night to remember, Dr. Stover admitted, but not nearly as exciting as another one 26 years later when he sat on the edge of a bleacher seat and watched little Chandler High knock Boonville out of the sectional, 48-47, in an overtime thriller.

What made it most exciting for him was the fact that son Jack had led Boonville back from a 28-21 deficit and with two minutes to go hit a dazzling long shot that gave the Pioneers a 39-38 lead. Then with time running out and Chandler again ahead, Jack hit another spectacular shot from the center of the floor to send the game into an overtime which Chandler finally won.

Later when son No. 2, Kenneth, arrived at the varsity sports level the good doctor became a dedicated track fan, for Kenny was the best hurdler in southern Indiana in 1956. He was the only double winner in the Evansville sectional, finished second in the high hurdles in the regional and fourth in the state meet.

Such were the life and times of a former flight surgeon and sports fan who never quite made it far enough to be called "Old Doc Stover" as he had anticipated.—*The Evansville Press*, Aug. 17, 1968.

Med School Dollars and Sense

Two dollars and sense reasons why Northwest Indiana is the logical site for a new Indiana University medical school were outlined to the Indiana Policy Commission on Post High School Education in a Lake County hearing last week.

They must be emphasized and re-emphasized in hearings leading up to and during the next session of the Indiana Legislature which convenes in January.

One is that the Lake County doctor-

to-patient ratio of 1-to-1,296 means that location of the school in Lake County would be the most solid assurance of a sizable federal grant for such an institution which the entire state needs.

The other is the repeating of the offer of the Gary Catholic Diocese not only to donate the land on which such a school could be constructed, but also to build a 300-bed teaching hospital nearby.

Neither was new.

Both, however, are the sort of points which other state communities bidding for the medical school will attempt to brush over unless they are kept constantly in the forefront of the Lake County site campaign.

There are other logical reasons, of course, for the location of such an institution in our midst.

One is the obvious fact that this sector represents the biggest state concentration of population except for Marion County (Indianapolis), the site of the present school. Another is the nearness of the area to Chicago and the chance for cooperative work with the many medical facilities there. A third is the area's awakened concern over medical needs as reflected by the successful Greater Gary Joint Hospital Drive which has passed the $5 million mark in public solicitation.

But all the logic in the world won't win the school for this area unless it is constantly and aggressively brought to attention of the legislators. The campaign can't let up.—*Gary Post-Tribune*, Aug. 20, 1968.

Medical News

It is obvious that more doctors are needed. "Obvious" because it is difficult to secure the services of doctors. People wait in crowded offices. Doctors complain of overwork. The difficulty of securing the service of a physician at night and other odd hours is well known.

The correction of this condition also is obvious: Train more people to be physicians. Surely they could find a ready market for their skills.

Are more doctors being "made"?

This week's issue of the *AMA News* shows that there is some progress:

Five new medical schools in the United States will open this fall, bringing the total to 99. Nine thousand, six hundred and thirty-seven students are expected to be enrolled in first year classes, compared with 9,451 last year.

Dwight L. Wilbur, M.D., president of the AMA, has challenged all 210,384 members of the association to contribute $100 annually to medical education. If the members respond, this would make an annual total of more than $21 million.

An editorial in the *AMA News* closes with an appeal to the physicians, as follows:

"Physicians can set a remarkable example for the rest of their countrymen by accepting Dr. Wilbur's challenge. By uniting to give the $20 million or more a year to medical education, medicine can then ask the other groups for their financial help, knowing that physicians have set a bright example.

"The need to increase enrollments in medical schools and to provide the necessary financial support is urgent. Physicians have been given a stirring call to lead the way in meeting the need."

There is a common cynical assumption that doctors as a whole conspire to keep down the number of doctors to avoid competition. It is heartening to know that this does not appear to be true, and that the leaders in the profession are working in the other direction. Surely, at the present rate, it will be a long time before there are enough good doctors.

Another article in the *AMA News* concerns the need to educate more Negroes as doctors. Only 2.2% of the nation's physicians are Negroes. —*Martinsville Reporter*, Sept. 7, 1968. ◄

STATEMENT OF OWNERSHIP

Statement of ownership, management and circulation (Act of October 23, 1962; Section 4369, Title 39, United States Code)

1. Date of filing: September 24, 1968.

2. Title of Publication: THE JOURNAL of the Indiana State Medical Association.

3. Frequency of issue: Monthly.

4. Location of known office of publication: 3935 N. Meridian St., Indianapolis, Indiana 46208.

5. Location of the headquarters or general business offices of the publishers: 3935 N. Meridian St., Indianapolis, Indiana 46208.

6. Names and addresses of publisher, editor, and managing editor: Publisher. The Indiana State Medical Association, 3935 N. Meridian St., Indianapolis, Indiana 46208. Frank B. Ramsey, M.D., 1802 N. Illinois St., Indianapolis, Indiana 46202, Editor.

7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given): Indiana State Medical Association, 3935 N. Meridian St., Indianapolis, Indiana 46208.

8. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages or other securities: None.

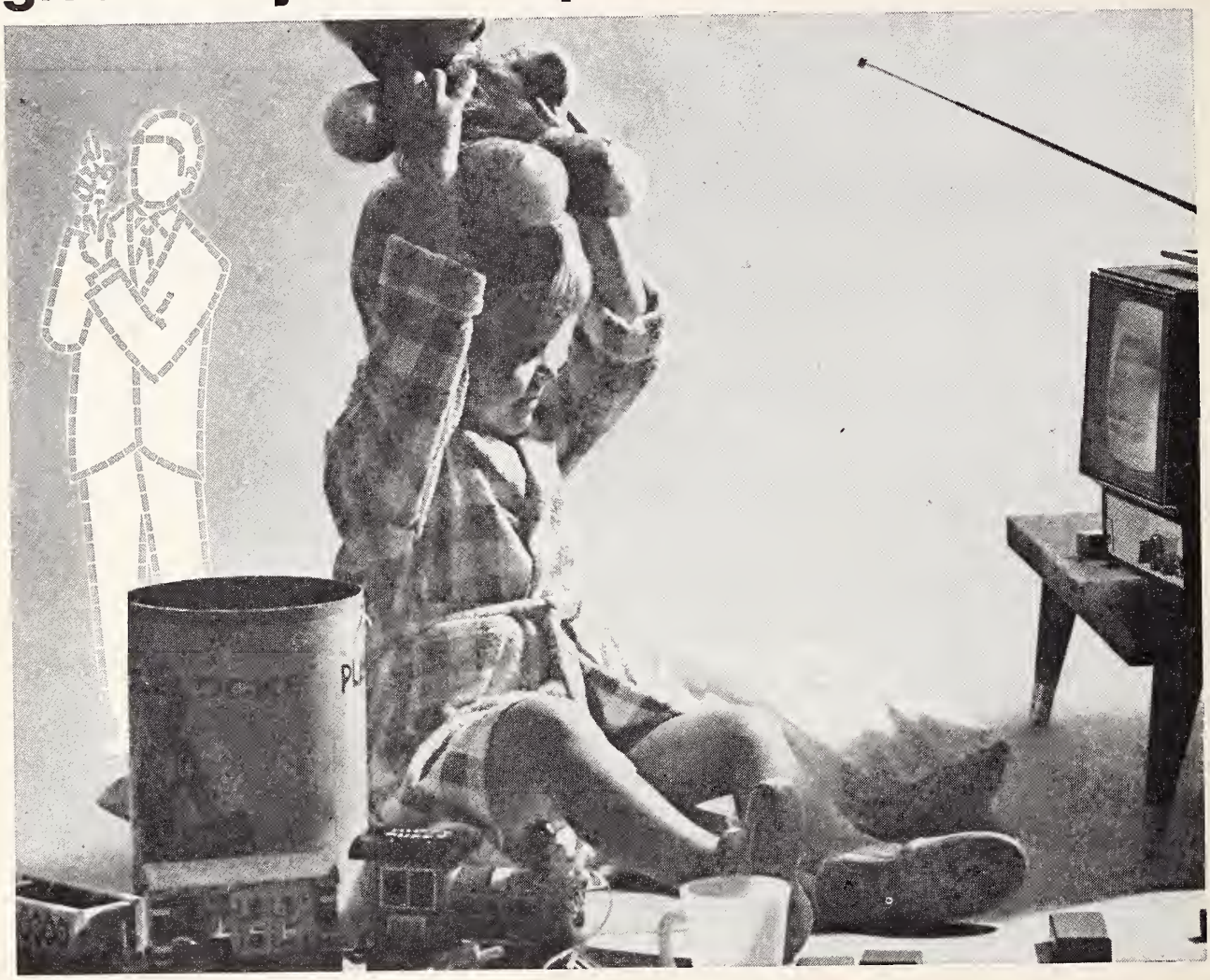
9. Paragraphs 7 and 8 include, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, also the statements in the two paragraphs show the affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner. Names and addresses of individuals who are stockholders of a corporation which itself is a stockholder or holder of bonds, mortgages or their securities of the publishing corporation have been included in paragraphs 7 and 8 when the interests of such individuals are equivalent to 1 percent or more of the total amount of the stock or securities of the publishing corporation.

10. The average No. of copies each issue during proceding 12 months are: (A) Total No. copies printed 4,900 (net press run). (B) Paid circulation: 1. Sales through dealers and carriers, street vendors and counter sales, 4,400. 2. Mail subscriptions, 100. (C) Total paid circulation, 4,500. (D) Free distribution (including samples) by mail, carrier or other means, 150. (E) Total distribution (sum of C and D), 4,650. (F) Office use, leftover, uncounted, spoiled after printing, 250. (G) Total (sum of E & F—should equal net press run shown in A), 4,900. No. of copies single issue nearest to filing date are (A) Total No. copies printed (net press run), 4,900. (B) Paid circulation: 1. Sales through dealers and carriers, street vendors and counter sales, 4,400. 2. Mail subscriptions, 100. (C) Total paid circulation, 4,500. (D) Free distribution (including samples) by mail, carrier or other means, 200. (E) Total distribution (sum of C and D), 4,700. (F) Office use, leftover, uncounted, spoiled after printing, 200. (G) Total (sum of E & F—should equal net press run shown in A), 4,900.

I certify that the statements made by me above are correct and complete.

James A. Waggener
Business Manager

It's almost as if you were there to give an injection of penicillin



V-Cillin K®, Pediatric dependable oral penicillin therapy

Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567A]

800198

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206

Lilly

The Journal of the INDIANA STATE MEDICAL ASSOCIATION
Supervised by THE COUNCIL
Volume 61 — November 1968 — Number 11

The second article in a series on aviation medicine considers the cardiopulmonary patient and commercial air travel.

The Evaluation of the Cardiopulmonary Patient for Air Travel

ROBERT B. STONEHILL, M.D.*
RAYMOND M. MURRAY, M.D.**
Indianapolis

THE number of patients traveling in commercial airplanes is increasing markedly. There are now over 84.5 million passengers carried on scheduled airlines in the United States per year.[1] If three percent of airline passengers are ambulatory patients,[2] there are over 2.5 million patients using this means of transportation each year. Experience has shown that more and more patients are turning to their physicians for advice and we must be prepared to give a reasonable, informed opinion. This paper will attempt to demonstrate a method of evaluation of the cardiopulmonary patient which can be done in the physician's office with tools and technics readily available to him.

First, however, it is appropriate to review some of the principles of altitude exposure as it affects cardiopulmonary physiology. The atmosphere is made up of a mixture of gases, 21% of which is oxygen. This percentage remains the same at higher altitudes. However, the atmospheric pressure decreases with altitude and therefore the molecules of the gases are farther apart. Thus, the partial pressure of oxygen is approximately 160 millimeters of mercury (mmHq) at sea level. At 18,000 feet it is only 80 mmHq. Thus, each breath of air contains less oxygen, lowering the oxygen concentration in the lung and blood and therefore, the oxyhemoglobin saturation in the blood (Figure 1).

Ventilatory Insufficiency

The principle compensatory effect brought into play in normal people is mild hyperventilation. However, individuals with significant lung pathology frequently have some degree of ventilatory impairment. There are two principal types of ventilatory in-

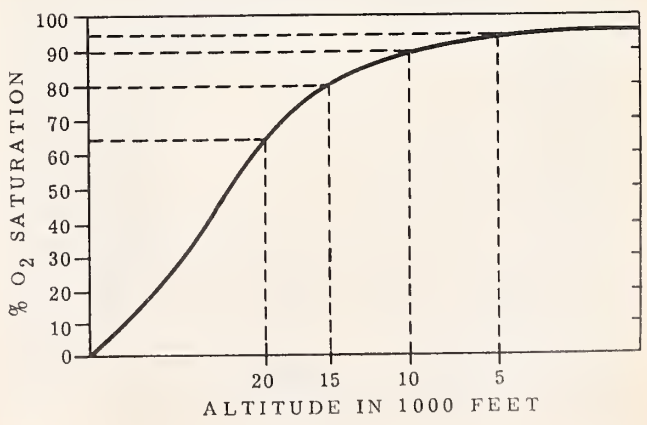


FIGURE 1

THE effect of altitude exposure on the oxyhemoglobin saturation.

* Professor of Medicine, Indiana University School of Medicine, Indianapolis 46202.

* Professor of Medicine, Indiana University School of Medicine, Indianapolis 46202.

sufficiency — obstructive and restrictive.

Obstructive insufficiency results from impairment of the passage of gas through the trachea, bronchi and bronchioles, and is usually more severe during expiration when the natural narrowing and shortening of these passages occurs. This usually results in obstruction to complete expiration and hyperinflation of the lung. Examples of this condition are chronic bronchitis and pulmonary emphysema.

Restrictive insufficiency means the reduction of the number of functional alveoli available for respiration as in pneumonia, after pulmonary resection or with pulmonary fibrosis. One restrictive defect which has special application to flying is pneumothorax. Here the trapped gases will tend to expand as the barometric pressure drops, resulting in compression of normal lung tissue and less and less available functional alveoli. This expansion could progress to the point where the usual negative intrathoracic pressure becomes positive and venous return to the heart would be impaired. Thus, both pulmonary and cardiovascular collapse could ensue.

Finally, the diffusion ability of the lung must be considered (Figure 2). If the normal composite barrier to oxygen between the blood and the alveolar space is increased with granuloma (such as sarcoidosis) or fluid (such as in pulmonary edema) altitude effect would be more severe. The use of supplemental oxygen would tend to overcome this defect.

Certain facts about commercial aircraft operations are important to consider. Most modern transports are pressurized. The air in the cabin is compressed so that the cabin atmosphere more closely approximates ground level than the altitude atmosphere through which the plane is flying. Recent propeller-piston aircraft have operational cabin altitudes of 4 to 6,000 feet. The turbo-prop or prop-jet aircraft has an operational cabin altitude of 5,000 feet. Large jet airliners have operational cabin altitudes of 6 to 8,000 feet while flying as high as 35,000 feet, and can attain a flying height of 23,000 feet while the cabin pressure is still equivalent to sea level.

It is also important to realize that the cardiopulmonary patient cannot expect much more attention from the cabin attendants than the regular passenger. He must be comfortable at ground level and be able to go through the ticketing and boarding procedures, which are at times somewhat strenuous. In case of a medical emergency once the plane is airborne, the nearest definitive treatment facilities are at a medical installation on the ground, reached only by debarkation.

Restrictive Disorders

Thus, the medical evaluation of the patient's capabilities is important. A careful history and physical examination is the most important part of the evaluation. The patient should be examined with the view to his functional capability. A chest x-ray is indicated to detect evidence of cor pulmonale, cardiac failure or pneumothorax. The red blood cell count or the hemoglobin determination will detect anemia. A red blood cell count of 2.5 million cells per cubic millimeter or less or a hemoglobin reduction of 50% or more are dangerous to air travelers. The composite picture of the blood electrolytes and blood pH will reveal the presence or absence of respiratory acidosis, and an electrocardiogram will aid in the cardiac evaluation. These procedures can all be done as an outpatient.

Acutely ill patients with conditions such as acute bronchial asthma or pneumonitis should not travel on commercial airlines. Their conditions tend to be unstable and could deteriorate rapidly while in flight.

Patients with obstructive ventilatory diseases suffer from the potential danger of carbon dioxide retention accompanying the hypoxia. If this situation exists, supplemental unsupervised oxygen administration could prove hazardous. One looks for the following evidence of increased severity in these conditions: blood oxyhemoglobin desaturation to a degree to cause cyanosis, respiratory acidosis and cor pulmonale. If cyanosis alone is present, the maximum cabin altitude limitation should be 6,000 feet (Table 1). If two of the three increased signs of severity mentioned above are present, the maximum cabin altitude exposure should be 4,000 feet.

In restrictive disorders, carbon dioxide retention is seldom a problem and supplemental oxygen can be given with safety. Without supplemental oxygen, a cyanotic patient with a restrictive ventilatory defect should have a cabin altitude limitation of 4 to 6,000 feet (Table II). However, if supplemental oxygen is available, cabin altitude exposures up to 8,000 feet should be permitted.

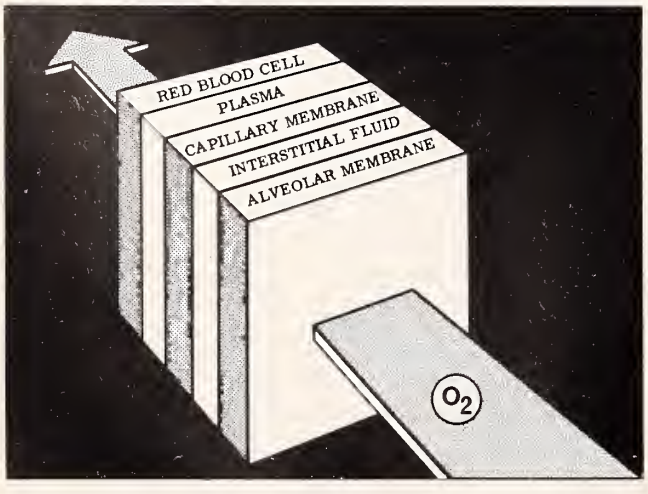


FIGURE 2

THE interface between the alveolus and the red blood cell.

CABIN ALTITUDE LIMITATIONS FOR PULMONARY PATIENTS

Cabin Altitude	Condition
8,000 feet	Minimal impairment
6,000 feet	Cyanosis + Emphysema + Restrictive defect + Diffusion defect
4,000 feet	Emphysema + Indications of increased severity
	Severely affected cyanotic restrictive defect

TABLE 1

The patient with alveolocapillary block and reduced oxygen diffusibility should have a 6,000 foot limitation unless supplemental oxygen is administered.

The Cardiac Patient

In the evaluation of cardiac patients, several considerations are of major importance: the presence and severity of coronary artery disease, the degree of heart failure, serious arrhythmias and exercise tolerance. These factors must be related to the air travel conditions which may induce hypoxia or significantly increase cardiac work.

One of the more important periods of stress for the air traveler occurs on the ground. The patient must be able to endure the boarding procedures, the long walks and luggage handling burdens at the modern air terminals without deleterious effects.

While exposure to altitude with its inherent hypoxia will increase the cardiac stress, the cabin altitude utilized in all commercial aircraft is of such a low level that this is relatively mild. Thus, a patient with adequate functional reserve at sea level should have a cabin altitude limitation of 8,000 feet, while a patient with a significant degree of heart failure or severe or unstable angina pectoris should be restricted to cabin altitudes of 6.000 feet or less unless supplemental oxygen is available (Table 2). Patients with uncomplicated hypertension, mild (treated) heart failure, minor arrhythmias, and mild-to-moderate peripheral vascular disease can usually tolerate all air travel conditions without problems.

Anxiety can cause a significant increase in the work load of the heart, and a mild sedative prior to take-off may be indicated. Air sickness with its attendant nausea and vomiting can cause considerable exertion. This is prevented best by the use of one one of the antimotion-sickness medications and a light meal prior to the flight. Modern jet aircraft with their higher flying altitudes and radar equipment minimize air turbulence which promotes air sickness.

Prolonged sitting will tend to cause circulatory stasis in the legs, particularly in patients with heart failure, and occasionally phlebothrombosis may result. All patients with heart failure and peripheral circulation disorders should be advised to use intermittent mild leg exercises while seated and to get up and move about the cabin periodically on flights lasting over one hour. The shorter flight durations of modern aircraft reduce this hazard.

Special diets are not generally available at eating facilities at the airport or on the plane. Advanced arrangements must be made for patients who require a low salt diet or other special diets.

In preparation for the flight, the cardiac patient should be carefully evaluated with a careful history and physical examination and pertinent laboratory work which may include an electrocardiogram, chest x-ray and blood chemistries. He should be placed on a suitable treatment program to achieve an optimal condition by flight time.

Special arrangements with the airlines may be necessary and should be made well in advance of the proposed trip. Information concerning operational and cabin altitudes may be important. Arrangements for assistance with ground transportation, luggage handling, special in-flight diets and supplementary oxygen can be made. Airline cooperation is usually excellent.

Summary

With the increasing popularity of air travel, more and more ambulatory cardiopulmonary patients are going to ask their physicians for advice concerning commercial flying. An informed opinion can be made of the patient's ability to utilize this means of transportation, utilizing

CABIN ALTITUDE LIMITATIONS FOR CARDIAC PATIENTS

Cabin Altitude	Condition
8,000 feet	Major cardiac disorders with adequate functional reserve at sea level
6,000 feet	Cardiac conditions where myocardial oxygenation is marginal

TABLE II

technics and procedures readily available in office practice. The physician may determine that special considerations will be required to aid in the safety of his patient, such as: supplemental oxygen, special diets or aid in the ticketing and boarding procedures. These requirements should be made known to the airline, well in advance of the proposed trip. Cooperation in this respect from the airlines has generally been excellent.

BIBLIOGRAPHY

1. Certificated Route Air Carriers — Selected Traffic and Financial Statistics — Fiscal Year 1965, Office of Management Services, Data Systems Division of the Federal Aviation Agency.

2. Armstrong, H. G.: Air Travel and Ambulatory Patient, International Forum, Vol. 4, No. 1, *Therap. Notes* 63:13, 1956. ◄

CIRCULAR IT-3
(Revised)

August 28, 1968

SUBJECT: TAX STATUS OF PARTNERSHIPS UNDER THE INDIANA ADJUSTED GROSS INCOME TAX ACT

This circular replaces Circular IT-3 dated August 2, 1965. On and after the above date, August 28, 1968, all statements contained in previous circulars issued by the Department, which are in conflict herewith, are null and void.

All words in *this style type* represent changes in this circular.

GENERAL STATEMENT: Partnerships are not subject to tax under the Adjusted Gross Income Tax Act. They will, however, file an information return as they do under the Internal Revenue Code, and the partners will be taxable as individuals under the Adjusted Gross Income Tax Act on their distributive share of the partnership income.

PARTNERSHIP FILING REQUIREMENTS: The partnership return of income is reported on Form IT-65, which must be filed on or before the 15th day of the 4th month following the close of the taxable year of the partnership. Every partnership must withhold an amount equal to two percent (2%) from any amount(s) paid or credited to the respective partners on account of their distributive shares of partnership income. Nonresident partnerships are required to withhold from the distributive share of partnership profits which are derived from activities or sources within Indiana. For further information, refer to Circular WH-6.

RESIDENT PARTNER: A partner who is a resident of Indiana must report on his Indiana Individual Income Tax Return, Form IT-40, his full distributive share of partnership income no matter where the partnership business is located or in what state(s) the partnership does business.

NONRESIDENT PARTNER: A nonresident partner must report on his Indiana Nonresident Individual Income Tax Return, Form IT-40NR, that part of the distributed and undistributed partnership income that was derived from sources within Indiana. If the partnership's income within and without Indiana cannot be separated for the nonresident partner, the income may be apportioned. Reference is made to Section 204 (c) of the Adjusted Gross Income Tax Act in applying a three-factor formula. If any other method is used, approval of the alternate method must be secured from the Department.

PARTNERSHIPS FILING AS CORPORATIONS: Partnerships which have elected under Section 1361 of the Internal Revenue Code to be taxed as corporations must file as a corporation for Indiana income tax purposes, and will thus be subject to different rules than those for partnerships. This election will not be allowed after January 1, 1969, since this section of the Internal Revenue Code has been repealed.

(S) .....
Wm. L. Fortune
Commissioner

THE FOREGOING INTERPRETATIONS WILL BE ADHERED TO AND APPLIED UNTIL CHANGED OR RESCINDED BY THE DEPARTMENT OF REVENUE, OR UNTIL REPLACED BY OFFICIAL REGULATION, OR NULLIFIED BY COURT DECISION.

Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done... in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220
A·H·ROBINS

in sinusitis, colds, U.R.I.
Dimetapp® Extentabs®

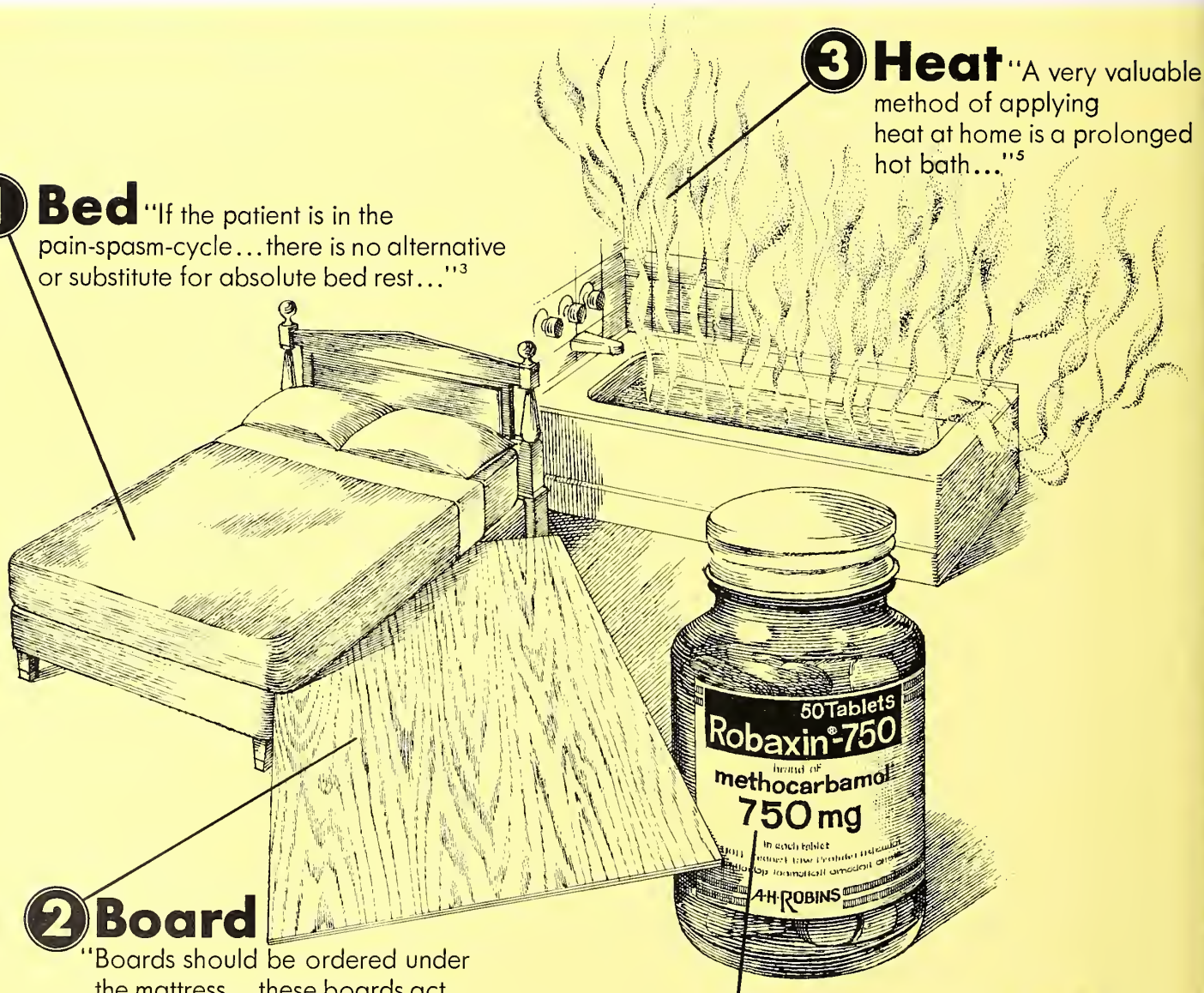
(Dimetane® [brompheniramine maleate], 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

up to 10-12 hours clear breathing on one tablet

LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:



1 Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

2 Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

3 Heat "A very valuable method of applying heat at home is a prolonged hot bath..."[5]

4 Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

Indicated far relief af skeletal muscle spasm. **Contraindicated** in hypersensitive patients. **Side Effects** (lightheadedness, dizziness, drawsiness, nausea) may accur rarely, but usually disappear an reduced dasage. Hypersensitivity reactians develap infrequently. See praduct literature far further details. **Also available:** Rabaxin® Tablets (methacarbamal, 500 mg.) Rabaxin Injectable (methacarbamal, 1 Gm./10 cc.)

References: (1). Gadfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gattschalk, L.A.: GP 33:91, 1966. (3). Rawe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cozen, L.: Sauth Dakata J. Med. 18:26, 1965. (5). Sata-Hall, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteapath. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New Yark J. Med. 62:1985, 1962.

A·H·ROBINS A. H. ROBINS COMPANY RICHMOND, VIRGINIA 23220

Coronary heart disease is the greatest single killer in the United States. Cardiogenic shock, the most serious complication of acute myocardial infarction, is discussed and recommendations made for treatment.

Cardiogenic Shock in Acute Myocardial Infarction*

A. D. DENNISON, JR., M.D.
Milligan, Tenn.**

NOAH Webster's wife, returning from a long trip, discovered the famous lexicographer "in flagrante delicto" with a pretty chambermaid. "Mr. Webster!" she gasped. "I am surprised!" "No, my dear," said Webster with a reproving smile, "You are shocked; I am surprised." Even Noah Webster with his exactness for the work "shock" here would have difficulty defining, describing, delineating cardiogenic shock. It represents the most serious complication of acute myocardial infarction and the availability of coronary care units has not altered mortality from this disorder.

Coronary heart disease is the greatest single killer in the United States, wiping out the equivalent of the population of an entire Marion County each year. Cardiogenic shock is responsible for a major portion of the deaths due to acute myocardial infarction. Leslie Kuhn, in a recent appraisal of this problem in the *American Heart Journal* indicates that several hundred thousand patients in the United States alone die of this syndrome each year.

Clinical Criteria

Shock may be defined in terms of its clinical manifestations or its pathophysiology. For the purpose of bedside diagnosis and management, it is best classified as a clinical syndrome due to acute circulatory failure and characterized by:

1. Hypotension, arterial.
2. Oliguria.
3. Sympathomimetic signs—rapid pulse, diaphoresis, cold skin—especially of the extremities.
4. The proper clinical setting—that is, in the presence of acute necrosis of the myocardium. It should be added that there is a great probability that congestive heart failure will also appear in this clinical tableau.

Pathophysiology

T. Joseph Reeves in commenting editorially on a publication which appeared in *Circulation on Hemodynamic Studies in Shock* gives a dismal report: "We know a great deal more than we did 30 years ago, but the patients *still* almost always die." The literature is difficult to evaluate because of different criteria for shock, but more especially because hemodynamic measurements have been obtained usually at a single point in time and at varying stages of the shock.

From the pathophysiologic viewpoint, shock may be defined as acute circulatory failure characterized by:

1. Reduction in cardiac output. This reduction is significant, by at least 30-40%, occurs very rapidly, and is the most consistent hemodynamic abnormality in shock.
2. Hypotension.
3. Tissue hypoxia. Jeopardizes microcirculation; invites acidosis.
4. Proper clinical setting.
5. Blood volume is characteristically unaltered in cardiogenic shock.
6. Careful analysis of hemodynamic alterations in both experimental and acute myocardial infarction with shock in man reveals a variety of patterns, and disproportionate increase of systemic vascular resistance is by no means universally present.
7. The systemic venous pressure is normal, low or increased, the latter an indication of congestive heart failure.

Clinical Portrait

1. Hypotension—Systolic pressure of 80 mm. or less. This is the sine qua non (the indispensable feature). But this alone is inadequate to make the diagnosis. It could be due to excessive doses of opiates or sedatives. The literature is engorged with differing figures for the incidence of

* Presented as part of a postgraduate course on "Care of the Patient with Acute Myocardial Infarction," Methodist Hospital Graduate Medical Center, December 6, 1967.

** A former Indianapolis cardiologist, Dr. Dennison is currently Regional Director, East Tennessee Heart, Cancer and Stroke Program, based at Milligan College, Milligan, Tenn. 34682.

cardiogenic shock and its resultant mortality. Undoubtedly this has come about because the criteria for shock have not been clearly and rigidly defined. There are valid reasons for insisting that an unequivocal diagnosis of shock requires that the systolic blood pressure be below 80 mm. Hg., even in patients who were hypertensive before the myocardial infarction.

2. Decreased pulse pressure.
3. Feeble pulse.
4. Tachycardia.
5. Dulled sensorium—obtundity or torpidity.
6. Cold, clammy skin—especially of the extremities.
7. Increased respiratory rate.
8. Prolonged circulation time.
9. Normal, low or increased venous pressure.
10. Oliguria — the kidney is a wonderful flow meter and oliguria is a clinical index of inadequate perfusion of renal tissue. A urinary flow of less than 20 cc. per hour as measured accurately with the aid of an indwelling Foley catheter usually indicates an inadequate splanchnic flow compatible with shock.

To this above potpourri (medley) of clinical features may be added the traditional findings in congestive heart failure. Kuhn has clearly pointed out that shock and failure may coexist; the shock may result as a later complication of severe congestive heart failure or congestive heart failure may develop later in the course of the shock. One can easily see that shock invites failure through diminution of coronary perfusion pressure, coronary flow and resultant deterioration of left ventricular function.

Prevention

Practical therapy indicates that time is the essence of management and that prevention of shock or establishment of early therapy is the first dictum. It can frequently be prevented by prompt relief of pain, by oxygen and by heparin administration. In a series of 134 patients with severe shock, of the 60 who received routine morphine, oxygen and heparin within three hours from the onset of myocardial infarction, 41 recovered from shock without additional therapy and 11 with additional therapy—a recovery rate of 87%. Eight patients failed to respond to all additional measures, giving a mortality of only 13% of the 60 patients treated early. Of 74 patients treated after three hours from the onset of shock, only 18 (or 24%) recovered, 56 showed no response to heroic measures, giving a mortality of 76%, about par for the course in most reported series (Griffith).

Our plea again is very early, sensible, sensitive, judicious and yet aggressive therapy in patients with acute myocardial infarction. We need to "blanket" him with every possible protection. Looks are deceiving and suddenly the clinical panorama changes and we find ourselves facing a dangerous arrhythmia, cardiogenic shock, cardiac failure or all three. Looks are indeed deceiving.

A newspaper reporter learned this the hard way when he interviewed a grizzled old man, sitting with his hands folded in his lap, behind his farm house. "Sir, I'd like to know the secret of your long life," asked the reporter. "I drink a gallon of whiskey, smoke fifty cigars and go out with women every day of my life," said the man. "Remarkable!" responded the reporter, "and exactly how old are you?" "Twenty seven," was the feeble reply.

Treatment

Lown speaking of cardiogenic shock calls it one of the "unresolved problems in coronary care." He adds that "the extent of the infarction observed anatomically in these patients makes it unlikely that any medical program has much to offer." It is his belief that study will have to be directed to the area of mechanical cardiac support. Nevertheless we must embark on presently accepted therapy, perchance as St. Paul said, we "might save some of them." Thus we embark on our heroic adventure.

1. *Monitor blood pressure.*

2. *Monitor urinary volume*—an adequately sustained blood pressure is assessed by continuous measurement of urinary output, which should exceed 20 cc. per hour, provided the patient is satisfactorily hydrated.

3. *Monitor central venous pressure*—a long plastic catheter can be threaded from a medial antecubital vein into the central circulation. The manometer should be zeroed at the level of the midchest. If the central venous pressure is less than 8 cm. H_2O, rapid infusion of dextran should be started immediately. If this pretentious technic cannot be carried out, certainly the neck veins should be observed.

4. *Monitor the pH and the C_o2*—this can be venous, better still arterial. In some centers use of equipment that utilizes micro-analytical technics which permit the use of capillary blood and give prompt results have proved reliable. A knowledge of the electrolyte pattern is also valuable.

5. *Terminate any existing arrhythmia* that may be causing or contributing to the shock state.

6. *Heparin*—to prevent thromboembolism and sludging in the microcirculation. It is said to lower platelet adhesiveness and agglutination.

7. *Oxygen therapy*—is designed to correct arterial hypoxemia and tissue hypoxia and perhaps improve myocardial oxygenation in the marginal zones of infarcted heart muscle. Patients in shock from acute myocardial infarction were found to have a low arterial oxygen concentration.

8. *Digitalis*—Intravenous ouabain or Cedilanid-D. The hemodynamic effects of rapid digitalization in experimental cardiogenic shock re-

vealed some positive inotropic effects within eight minutes after administration (*Amer. Heart J.*, Feb., 1965). Digitalis is the classic drug for improving myocardial contractility, but not all of these patients are in congestive heart failure, at least initially.

9. *Vasopressor drugs*—first a beta-reactive catecholamine such as isoproterenol (Isuprel) is administered. The dosage is 1 to 5 mg. of the drug dissolved in 500 cc. of a 5% solution of dextrose in water, and the rate of flow is regulated to provide 0.3 to 2.0 cc. per minute. The rate of flow or concentration is increased if there is no favorable response. If blood pressure is unobtainable from the start or if Isuprel is ineffective, the alpha-reactive catecholamine norepinephrine (Levophed) is employed. Two to four ampules are dissolved in 1000 cc. of 5% dextrose in water. The solution is administered intravenously as a continuous drip at a rate sufficient to maintain a systolic blood pressure of 80 to 90 mm. Hg. This has been our mistake in the past — driving the heart too much and demanding higher blood pressure figures. If we do this, coronary blood flow may increase, but oxygen consumption may increase relatively more. A study on myocardial infarction with shock reported in *Circulation* in May, 1966, did not favor Aramine over the other two agents because of its greater lack of inotropic activity.

10. *Dextran*—low molecular weight dextran is administered to promote tissue blood flow and increase urinary output. At Methodist Hospital in Indianapolis we had available Rheomacrodex (dextran 40) and also the Abbott preparation (LMD 10%) with a low molecular weight of 40,000. Both of these preparations are put up in 500 cc. volume in dextrose and water. The dextran is given to lower plasma viscosity, prevent cellular aggregation in the microcirculation, and thus improve flow properties of the blood. We speak of them as volume and plasma expanders. The neck veins, the central venous pressure, the clinical profile must be observed as congestive heart failure may be precipitated by too large or too rapid infusions of this agent.

11. *Correction of lactic acidosis*—With severe anoxia, so prevalent in this syndrome, various splanchnic tissues, in addition to ischemic heart muscle, undergo anaerobic metabolism and give rise to lactic acid. Profound acidosis occurs in every case of shock and it must be combated vigorously, for uncontrolled acidosis leads to lethal ventricular arrhythmias and irreversible shock. Monitoring of the blood pH in acute myocardial infarction has disclosed consistent metabolic acidosis in patients with shock, pulmonary edema or serious arrhythmia. This state must be combated with the infusion of bicarbonate or THAM-E. Bicarbonate comes in ampules of 40 mEq./l or in infusions of 300 mEq./l in 500 cc. volume.

12. *Steroids*—no medical presentation would be complete without mentioning the last court of resort in all therapies — glucocorticoids — employment of massive doses of Solu-Medrol or Solu-Cortef (the latter retaining sodium more intensely). The doses recommended are astronomical with 500 to 1000 mgms. of hydrocortisone mentioned in our cardiac literature. Steroids appear to reduce systemic vascular resistance and increase blood flow. Unfortunately, a double-blind study by the Scottish Society of Physicians in 1964 disclosed that corticosteroids resulted in no improvement in mortality of patients with severe myocardial infarction. I have used these agents and would criticize no one who did so as a measure of desperation.

Summary

Cardiogenic shock is a hated and feared complication of acute myocardial infarction. Our hope for the future rests in experimental technics under investigation—hypothermia, hyperbaric oxygen, counterpulsation, bypass procedures, specialized pacing technics, the artificial heart and least likely, the vasodilating drugs.

Parke-Davis placed an interesting advertisement in a recent issue of *The Reader's Digest*. It portrayed a massive turtle and underneath were the words, "If a turtle can live for 138 years, why can't you?" Consider the human heart. Some authorities believe it has the potential to last for perhaps 150 years. Yet, the heart often falters or fails in mid-years. Can we not dream dreams of better future care for the patient slaughtered and assaulted by coronary artery disease? ◄

Human behavior is likened to the output of a computer. Abnormal behavior may be due to faulty programming. Psychiatric interview should discover the error in programming and re-program the computer properly.

Some Contributions of Communication Theory to Psychotherapy

JAMES M. DONAHUE, M.D.
Indianapolis

MOST physicians have had some exposure to psychology or to psychiatric theory during the course of their professional education. However, many physicians in fields other than psychiatry are not aware of the recent advances that have been taking place here, particularly in the area of therapy. It seems that the knowledge many physicians have of psychiatric therapy begins and ends with psychoanalysis, and there is relatively little general knowledge of the ferment going on in this area in the last several years. Many of the recent advances haven't yet found their way into textbooks or widely read professional journals.

Most physicians have become acquainted with the basic psychoanalytic concepts as elaborated by Sigmund Freud and other pioneer psychiatrists early in this century. They include such ideas as the existence of a "dynamic unconscious"; the division of the mind into ego, superego and id, and a view of human behavior as being largely determined by sexual instincts which, if not properly channeled and released, can lead to trouble. These ideas have held sway in psychiatry for a number of decades. Valuable and pioneering as they were, in recent years we have progressed a good distance beyond them. Of particular significance has been the introduction of the study of human behavior from a communicative point of view, or the "black box" theory of human behavior.[1]

An Inner Computer

In thinking along these lines, the human being is seen not so much as a biologic organism but as a communicating machine—actually a partially self-programming, high speed analogue computer housed in a biologic shelter. Nearly all human behavior is seen as being intended to communicate messages. This computer-like mechanism has certain very definite characteristics and operating laws.

For purposes of clarification it can be compared to a TV set, composed of three parts. The first part is the antenna, where the communicated signals enter the mechanism. Then there is a "black box" which contains electronic circuitry interconnected to perform certain functions. The third part is the output, which in the case of a TV set is the picture and sound. Similarly, for communications purposes, we can think of a human as being composed of three parts. The input consists of the five senses—all the things we see, hear, touch, taste and smell. The "black box" is represented by the central nervous system which contains neurocircuitry to perform certain functions. The output is seen as behavior, or in general anything a human being does that is perceived by others. Thus the function is largely one of receiving, handling and sending messages.

These messages have several peculiarities of their own. They have two components: verbal and nonverbal. The verbal component is of course made up of the words one person says to another. At a more abstract level we can think of this as a coded message sent from one person to another. The nonverbal component consists of such things as voice inflection, facial expression, gestures and attitude or mood. These augment the verbal content of the message in such a way that we can think of them as a set of instructions sent along with the message on how to decode and interpret them.

Sending and Receiving

Some illustrative examples may be in order. The typical scene of a husband and wife at home in the evening conversing with each other presents one:

Wife: "How was your day today, dear?"

Husband: "Oh, I don't know. About the usual I guess. How was your day?"

Wife: "Well, nothing too much happened. Johnny was a little better behaved than yesterday. I had a phone call from your brother this morning and . . . ."

Here the verbal content of the messages seems to have no unusual significance. The nonverbal com-

ponent says simply, "I'm tuned in, I'm sending and receiving, the content of this message has only routine importance." It seems to be characteristic of human beings that they tend to frequently check their communicative channels with routine messages to see that they are functioning normally.

A second example is furnished by a recent TV commercial:

A scene is presented advertising a proprietary headache remedy wherein a man arrives home from work, obviously feeling angry and frustrated. As he turns into his driveway he accidentally runs into a tricycle which one of his children left there. He jumps out of his car with clenched fists and yells at his wife:

"Alice, how many times have I told you to see that the kids keep their toys out of the driveway!"

Here the nonverbal component of the message would read, "I'm angry and frustrated, disregard the content of this message, it has no implicit importance."

Example number 3:

A three-year-old child is playing in his home in the evening. He gets into some mischief which comes to the attention of his mother, who gives him a spanking. Things then return to normal, and shortly thereafter the child goes to bed. After lying in bed a few minutes he cries out:

"Mother, I want a drink of water." Or, "Mother, I have a stomach ache." Or, "Mother, my head hurts and I can't go to sleep."

Here the nonverbal component of the child's message says something like this: "Mother, do you still love me, are we still friends, are you still willing to talk to me?" The perceptive, intuitive mother recognizes this automatically and gives the child a drink of water or whatever, thus reassuring him.

But suppose mother has had a bad day too and is feeling irritable and impatient. Then instead of being gentle and understanding she might snap at the child or even give him another spanking, in other words communicating the irate husband's message in the previous example. Since a three-year-old child isn't yet communicating well enough to understand the nonverbal component of this message ("I'm angry and frustrated, disregard the content of this message") he would very likely become more anxious and upset and might begin to cry. A child has to be around ten years old before he can correctly interpret this type of message.

Faulty Programming

In other words the "black box" with which we communicate is programmed by feeding it a graded series of instructions of gradually increasing complexity over a period of years. This process is usually called child rearing. We communicate in one fashion with a toddler, in a little bit different way with a preschool child, in a still different way with a child in the primary grades, and so on. If properly carried out, these various steps must not be mixed up or trouble will result. The example above of the irritable mother illustrates this.

Another common example is seen in a household with a teenage son who wants to use the family car on Saturday night. Perhaps father is feeling temperamental at the end of the week and puts his foot down firmly and in no uncertain terms, telling the boy that he can't use the car like he would have told him at six years old that he couldn't cross the street with his bicycle. Here again the wrong level of communication has been used and the son will quite likely react with resentment and hostility.

It appears that in psychiatry today we deal with basically two different kinds of problems: communication problems perhaps due to faulty programming where the "black box" itself is intact, and cases where the "black box" has been damaged or isn't operating properly. Examples of the second type of problem, where the "black box" is damaged, come to mind readily. The alcoholic with delirium tremens is an obvious one. Here we are dealing with a chemical imbalance and a temporary derangement in the ability to process information. Severe head injuries, cerebral vascular accidents or congenital brain damage may also physically affect the ability to process information.

A similar condition results from what may be thought of as input overload. wherein the information-processing ability is temporarily lost much as if a sudden surge in line voltage were to occur and cause a TV set to short circuit. This is what happens during war time in combat fatigue, when a soldier may emotionally break down after several days of continuous combat and heavy bombardment. In civilian practice we see a similar situation occasionally after severe catastrophes such as a patient's house burning down and killing members of his family. In this case the "black box" is functionally deranged, and it will usually return spontaneously to normal functioning if allowed a period of rest.

In the opposite direction abnormalities of input underload occur. Here we find that when the environment does not supply a sufficient amount of sensory input to the "black box," the circuitry of the box usually provides an artificial input in an attempt to cover the deficit. Thus psychological sensory isolation experiments reveal that apparently all normal persons will begin to hallucinate after several hours of absolute sensory deprivation. Similarly, convicts in solitary confinement in prisons may deteriorate emotionally. Elderly people at night when the house is quiet and there is very little sensory input may begin to hallucinate, or to find they have a very vivid imagination. Jet pilots flying at high altitudes may experience what has been called the

"breaking off" phenomenon.[2] Clinical management of cases in this category is often more complicated, but generally speaking again the communicative apparatus can be expected to return to normal functioning spontaneously unless secondary problems have developed. It should also be mentioned that there is some evidence that certain mental conditions now thought of as "functional" may ultimately be included under this category of deranged communicative apparatus, including some cases of schizophrenia and some types of depression.

The other type of difficulty mentioned was communication difficulties arising from faulty "programming" where the "black box" itself is intact. Under this heading are included such things as personality and character disorders, many sexual deviations and such troublesome personality traits as passive-aggressive conflicts with authority, and some neurotic symptoms such as phobias. Proper management of these conditions requires a slow, painstaking process of sitting down for several hours with the patient and sorting out the faulty instructions, finding the errors in programming and reprogramming the person to communicate properly. This is usually called psychotherapy. At the present time we must consider it to be still in developmental stages. It is time-consuming and expensive, but often extremely effective. We would consider in retrospect that Sigmund Freud and other of the psychoanalytic pioneers laid down many of the basic rules for this process without actually realizing it.

Psychiatry has made a good deal of progress in the last several years. There are still many unanswered questions, but it appears that at present the direction future research must take is well delineated in many areas. Ultimately it should be possible for the practicing physician who is not a psychiatrist to be much more effective and on much solider ground in his contact with psychiatrically disturbed patients.

BIBLIOGRAPHY

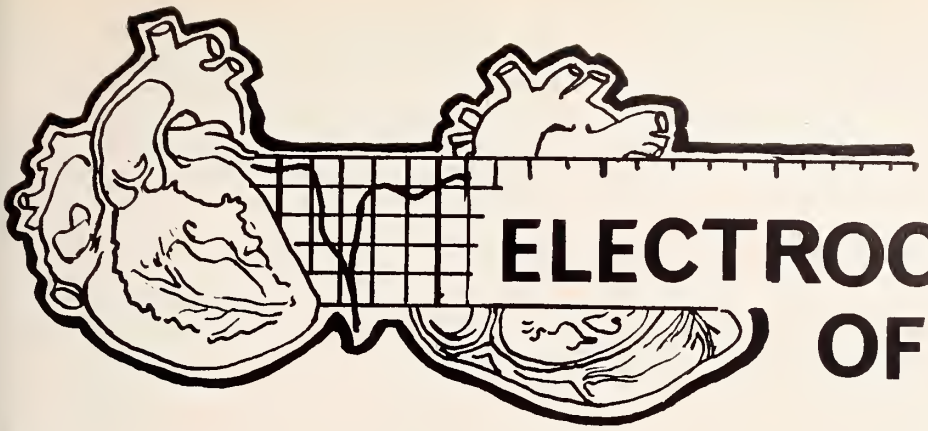
1. Watzlawick, et al.: *Pragmatics of Human Communication*, New York, W. W. Norton, 1967.
2. The "Break-off" Phenomenon. A Precipitant of Anxiety in Jet Aviators, *Arch. Gen. Psychiat.* 13:447, November, 1965. ◄

1815 N. Capitol Ave.
Indianapolis 46202

From *The Journal* 50 Years Ago

. . . The definition of fistula carries with it an idea of an unnatural channel, chronic in character, above the anus or rectum. The classification of these fistulae is not of such great interest. It may or may not be complete. It may or may not be above or below Hilton's line. It may or may not connect to other organs. Fistulae occur in one-third the number of rectal cases. The relation of tuberculosis and syphilis in the causation of fistula is not settled. No doubt tuberculosis plays some part, and no doubt the tubercule [sic] bacilli can be the cause primarily of a fistula. This, however, happens very rarely. In the majority of cases of tubercular fistulae the fistula occurs in the tuberculosis. Tuttle makes the statement that 50 percent of the cases of fistula which he saw had either had at the time, or later developed, tuberculosis. Running through the literature, the general opinion seems to be that 10 percent of fistulae are tuberculous.

One point that has always been of interest to me is, why do not these fistulae heal? Twenty-five to 40 percent operated on are failures, and why is this so? In some of the cases it is impossible to find the internal opening. This should not happen often. The infection in these cases undoubtedly takes place along the lymph tract. When the abscess drains, as it does periodically, the lymph canal is free to reinfect the cavity and keep it from healing; even though you are unable to find an opening into the bowel. In some cases, suppuration takes place along this tract and an opening into the bowel takes place later . . . . C. F. Fleming, M.D., Elkhart, "Fistula in Ano," *JISMA*, November, 1918.



ELECTROCARDIOGRAM OF THE MONTH

Nonparoxysmal Ventricular Tachycardia

CHARLES FISCH, M.D.
*Indianapolis**

WITH the advent of continuous monitoring of patients with acute myocardial infarction, the incidence of arrhythmias complicating acute infarction was found to vary from 70-80% from series to series. In addition some interesting forms of transient arrhythmias are recorded. One such arrhythmia is represented in the accompanying figure. It is a form of "slow" ventricular tachycardia which, as far as the evidence indicates, is benign and requires no therapy. For this reason it should be clearly separated from ordinary paroxysmal ventricular tachycardia.

Figure 1 represents lead II. The basic rhythm is sinus with a varying degree of A-V block. The S-T segments are elevated, attesting to the acuteness of the infarction. A short run of ventricular arrhythmias consisting of three complexes is seen in the upper row and another one consisting of six complexes is seen in the second row. The first complex of each run represents a fusion between the ectopic and SA impulses proving the ventricular origin of the arrhythmias. A single fusion beat is represented by the second complex in row 2. The gradual emergence and gradual disappearance of the arrhythmia in some way resembles the behavior of nonparoxysmal junctional (nodal) tachycardia and perhaps the arrhythmia should be referred to as nonparoxysmal ventricular tachycardia. ◄

* From the Krannert Institute of Cardiology, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.

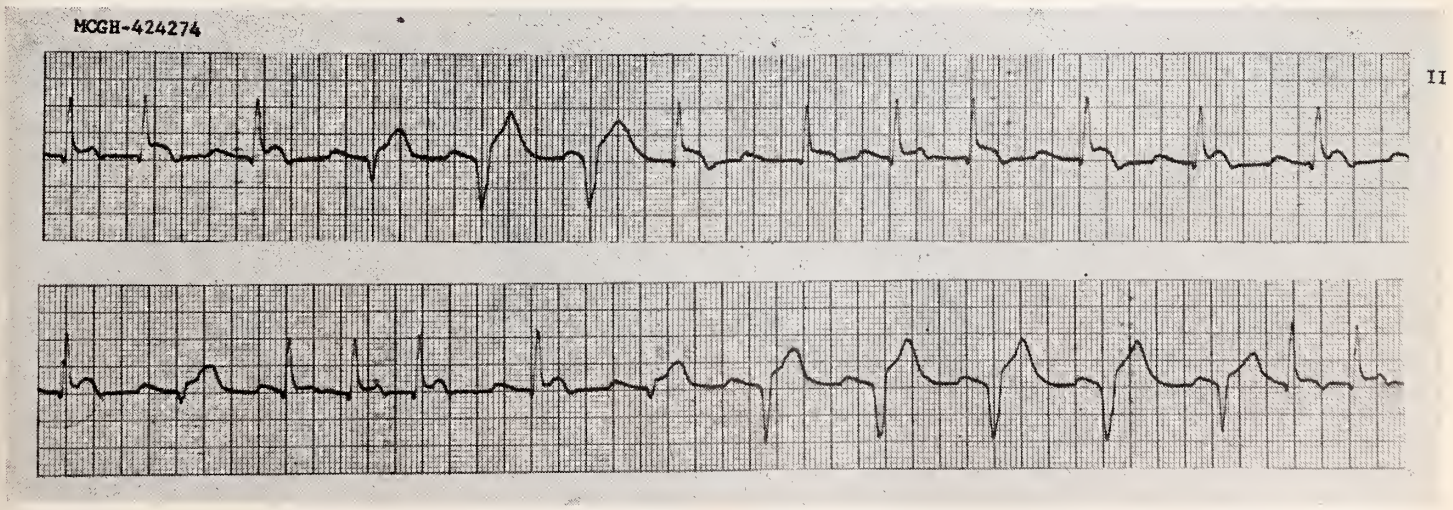


FIGURE 1
NONPAROXYSMAL ventricular tachycardia.

X-RAY CONFERENCE

Dissecting Aneurysm of the Descending Thoracic Aorta

ERICH K. LANG, M.D.
*Shreveport, La.**

THIS 75-year-old Creole was admitted with the complaint of severe chest pain. The patient related that two weeks prior to admission he was first troubled with back pain localizing between his shoulders. Since then the pain had intensified and was now deep seated in his back. Deep inspiration appeared to intensify the pain.

Physical examination at the time of admission showed no significant abnormalities other than a marked disparity of the blood pressure readings between the upper and lower extremities; the pressure recorded over the lower extremity being 60 points lower. The pertinent laboratory findings consisted of a positive Wassermann and treponema immobilization test, a hematocrit of 28, and a hemoglobin of 9.8. A chest roentgenogram revealed an irregularly contoured margin of the descending thoracic aorta and suggested the possibility of a dissecting aneurysm.

* Professor and Chairman, Department of Radiology, L. S. U. School of Medicine, Confederate Memorial Medical Center, Shreveport, La. 71106.

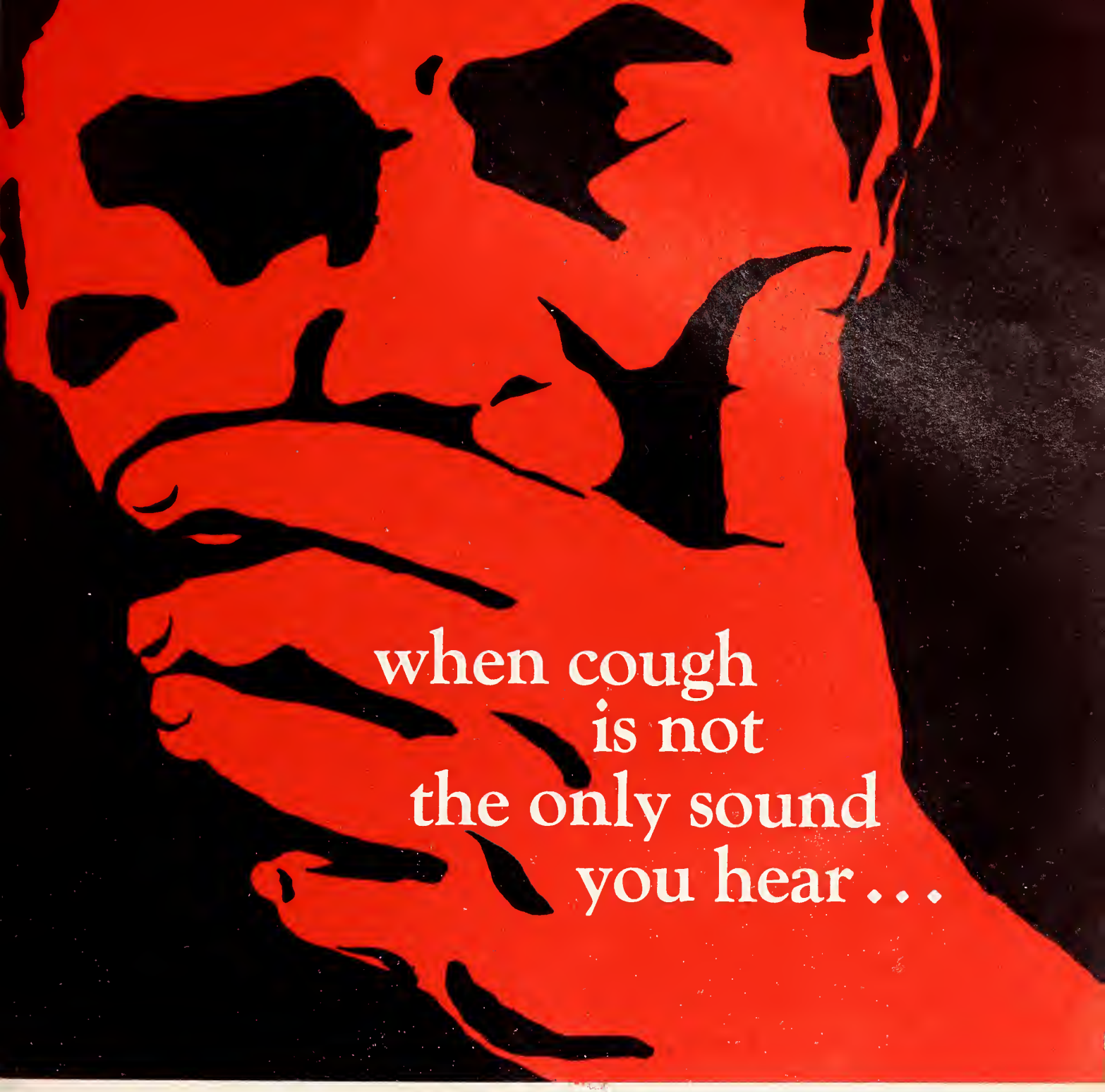
On the basis of the findings of the chest roentgenogram, a retrograde catheter aortogram was performed (Figure 1). The examination demonstrated a typical bamboo deformity of the descending thoracic aorta at the level of D8. Distal to this area, the patent channel of the aorta appeared to be narrowed; the cross diameter measured less than 1/3 the segment above the area of dissection. The soft tissue contour line suggested an extensive area of dissection with obvious clot formation, accounting for the entire soft tissue shadow forming the lateral margin of the distal segment of the aorta. The compromise of the lumen of the aorta readily explained the pressure gradient observed clinically.

FIGURE 1

NOTE the bamboo deformity of the descending thoracic aorta heralding the point where the dissection commences. A huge clot has formed in the dissected channel of the aorta (arrows, the remaining open lumen is significantly compromised).

Comment

Retrograde Seldinger arteriography is the recommended procedure for detailed assessment of the ascending and descending thoracic aorta, as well as the brachiocephalic vessels. The use of a soft tipped and curved spring guide has all but eliminated the danger of perforation of the aneurysm. The extremely elastic and curved tip will seek its way through the remaining lumen of the aorta and permit safe advancement of the follow-up catheter into the ascending aorta. Test injections monitored fluoroscopically ascertain the position of the catheter, which has to be proximal to the site of suspected aneurysm. A pressure injection can safely be carried out at this position, but should be avoided directly at the level of the aneurysm for fear of a blowout. The method is greatly favored over double venous aortography because of its better detail and definition permitting definitive assessment for surgery. ◄



OMNI-TUSS® b.i.d.

. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

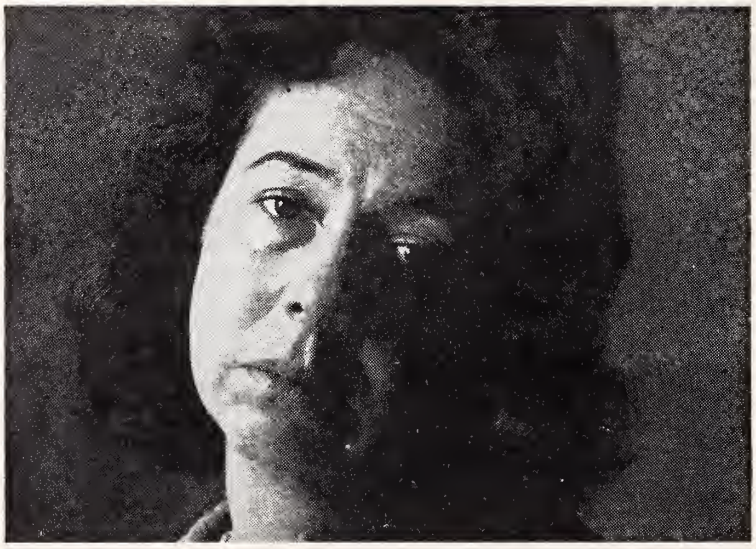
Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh
Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.

When it's more than a bad cold



your patient can feel better while she's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

327-8

FRACTURES AND ORTHOPEDIC PROBLEMS

"Fractures and Orthopedic Problems" is a feature which will appear regularly. It will outline conditions involving bones and joints which will be of interest to physicians in general and special types of practice. It is edited by George F. Rapp, M.D., of Indianapolis. The submission of short illustrated articles to this feature is invited.

Carpal Tunnel Syndrome, Failure of Surgery

WILLIAM A. STARK, M.D.
Michigan City, Ind.

THE rather commonly encountered condition of compression of the median nerve, known as the carpal tunnel syndrome, was first demonstrated at autopsy by Marie and Foix in 1913.[5] Previously, Putnam,[8] in 1880, had presented a series of cases of nocturnal median nerve paresthesia which clinically resembled the presently known carpal tunnel syndrome.

Anatomy

The bones of the carpus are joined together by interosseous ligaments forming a deep excavation for passage of tendons, vessels and nerves. The transverse carpal ligament then transforms this into a canal. The transverse carpal ligament is a heavy sheath of fascia which attaches on the ulnar side to the hook of the hamate and the pisiform and on the radial side to the crest of the multangulum major and the tuber of the navicular (Figure 1).[3] Through this tunnel passes the median nerve and all of the flexor tendons to the fingers. These flexor tendons are contained within a synovial sheath and the median nerve is attached rather firmly to this sheath.

Etiology

Symptoms of median neuropathy can be brought about by any condition that will produce an increase in pressure within the unyielding wall of the carpal tunnel. The most common cause of this is thickening of the flexor sheath. A great number of the cases of thickening of the tendon sheath are of a nonspecific nature. Arlet[1] found peripheral fibrosis of the synovial sheath in 34 consecutive histologic examinations of this condition. Space-taking lesions within the carpal tunnel such as lymphoma, hemangioma and ganglion can produce median nerve compression. It has also been reported as occurring with calcific deposits, gouty tophi and amyloid disease.[10] There have also been congenital anomalies within the carpal tunnel reported such as a prolonged flexor digitorum sublimis muscle belly and other anomalous muscles. In the person that is predisposed to carpal tunnel syndrome, activities necessitating repeated forceful flexion of the wrist and fingers will precipitate symptoms. The condition has also been associated with hormone changes such as menopause, acromegaly and pregnancy.[9]

The earliest pathologic manifestation of the nerve compression is a

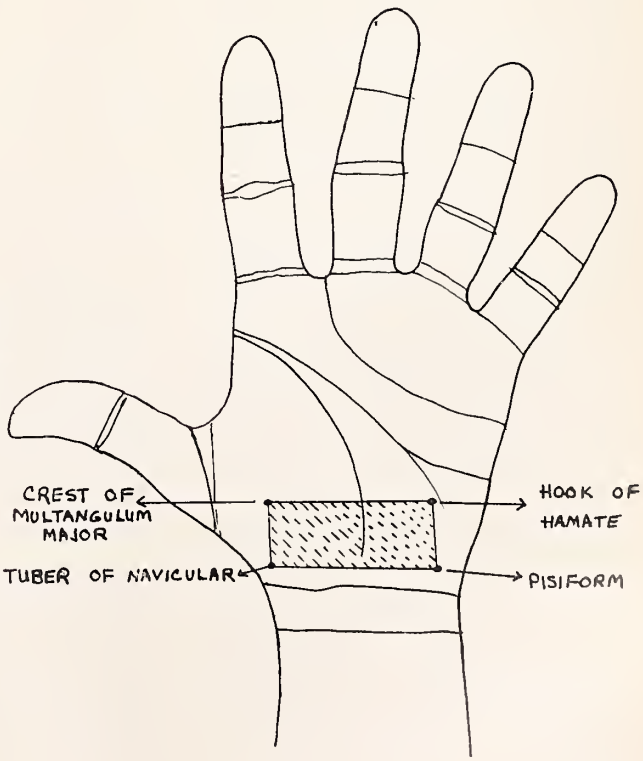


FIGURE 1
A diagram of the hand showing the relationships of the transverse carpal ligament to the creases of the hand.

segmental area of hyperemia at the level of the proximal third of the transverse carpal ligament. With more advanced disease, one finds constriction of the nerve (Figure 2).

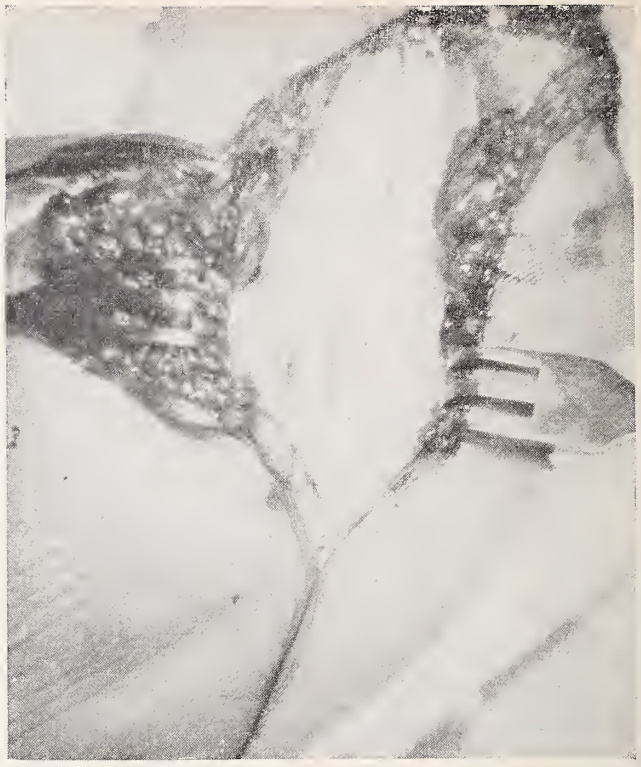


FIGURE 2

THE median nerve at the time of carpal tunnel decompression showing the narrowing of the nerve within the carpal tunnel with swelling proximal to the transverse carpal ligament.

Diagnosis

The diagnosis of carpal tunnel syndrome must be considered in any patient who presents with hypesthesia or paresthesias in the median nerve distribution. The condition is most commonly seen in women between the age of 30 to 50. The incidence of female to male sufferers has been approximately two to one. The condition has rarely been reported in children.[4] One of the characteristic complaints in this condition is that of nocturnal discomfort. The patient wakens with pain or tingling in the median nerve distribution. Very often he will first state that the entire hand tingles but further questioning will elicit information that the little finger is spared. Many of these people attain partial relief by shaking or massaging the hand and placing it in dependent position. Many of the patients have signs of vasospasm, such as sensitivity to cold, excess sweating or color changes. As the condition becomes more advanced, they will complain of clumsiness, particularly in trying to pick up small objects.

There are no objective signs early in this condition. The first objective evidence is hypesthesia in the median nerve distribution. In the majority of cases, a Tinel sign can be elicited over the carpal tunnel. As the condition becomes more advanced, thenar atrophy develops and with it, weakness. The first weakness that can be detected is in the abductor pollicis brevis muscle. If one acutely volar flexes the wrist, the symptoms of tingling and paresthesias will appear within a few seconds. Electromyography and electrical conduction studies are also of value in diagnosing this condition. The conduction time of the median nerve is uniformly prolonged.

Treatment

The treatment of the carpal tunnel syndrome has as its aim the relief of pressure on the median nerve. This can be done in some cases by conservative means but in others surgical means must be used.

In the individuals who note pain after certain activities, it is sometimes possible to relieve discomfort merely by cessation of these activities. The night pain can sometimes be relieved by night splinting in the position of function. In many cases the nonspecific tenosynovitis which is causing the median nerve pressure can be relieved by injection of hydrocortisone. Phalen[7] injected steroids in 41% of his cases. He reports that 24% of those injected were cured and 38% were improved. Only 60 of the 270 people who had injections needed surgery later. He reports that one of the patients in his series had 28 injections but he prefers to only use three or four before treating the patient surgically.

Surgery is indicated in those individuals who have had injections without significant relief or in whom other conservative means have failed. Surgery is indicated in any patient who has thenar atrophy. The object of the surgical operation is sectioning the transverse carpal ligament. This is usually done through a curved incision extending into the hand although Phalen[7] uses a small transverse incision. It is essential that all fibers of the transverse carpal ligament be sectioned.

This is quite difficult through a transverse incision, in that section of the distal portion of the ligament must be done blindly. Sectioning of the ligament is done along the ulnar side of the ligament. In many cases, particularly in rheumatoids, a partial synovectomy of the flexor tendon sheath is necessary along with the decompression.

At times it is valuable to sever the palmaris longus tendon in order to relieve pressure. In order to prevent "bow-stringing" of the tendons, Tanzer[9] sometimes partially closes the ligament with a pull-out wire. He does not close it completely.

Two case reports of carpal tunnel syndrome in which initial surgery was not successful are presented.

Case No. 1: A 46-year-old woman had had surgery performed for a carpal tunnel syndrome on the left. This surgical procedure was per-

formed through a transverse incision. The wound healed without difficulty and initially she was improved but still complained of some pain on the volar aspect of the forearm. Four weeks after surgery she complained of numbness of the index, long and ring fingers and pain in the forearm. The feeling of numbness in these fingers persisted and she again began having pain and tingling in the fingers at night, and was awakened repeatedly by the pain.

Approximately one year after the initial procedure, a second carpal tunnel decompression was performed. This procedure was done through a curved incision extending into the hand. The entire transverse carpal ligament was severed and the median nerve was found to have the typical narrowing within the carpal tunnel and enlargement proximal to the tunnel. The wound again healed well. She complained of a great deal of tenderness over the scar but lost the pain and numbness in the fingers and was no longer awakened by pain.

Case No. 2: A 57-year-old white female was first seen in January, 1967. She gave a history of having had a carpal tunnel decompression performed on the right in 1960. This did not relieve the numbness that she had in her thumb, index and long fingers. Her complaints were mainly of numbness but also some pain. She did not have night pain. The pain and numbness was aggravated by extensive use of the hands such as wringing out clothes. She had also had similar symptoms of the left wrist for approximately one year. She had had a scalenotomy performed on the right in the past in an attempt to relieve this discomfort.

On physical examination, there was considerable thenar atrophy on the right with weakness of all of the median innervated intrinsic muscles. The abductor pollicis brevis, flexor pollicis brevis and opponens pollicis were all rated at 3. All other muscles of the hand were normal. There was hypesthesia in the area over the volar aspect of the thumb, index and middle fingers of the right hand. There was a transverse scar over the volar aspect of the right wrist which gave a pronounced Tinel sign when tapped.

On the left there was hypesthesia over the thumb, index, long and radial half of the ring fingers. There was also a minimal Tinel sign over the volar aspect of the left wrist. The patient's symptoms were greatly aggravated by holding the wrists in volar flexion for approximately 30 seconds. The patient incidentally had an early Dupuytren's contracture of the right hand. X-rays of the wrists showed no significant abnormalities.

Bilateral carpal tunnel decompressions were performed. On the right there was marked narrowing of the nerve in the carpal tunnel with enlargement proximal to it. There was also intense vascular injection after the decompression. There were similar findings in the left but of a lesser degree. The wounds healed without difficulty. She continued to have numbness of the right hand. When last seen, nine months postoperatively, she still had marked thenar atrophy on the right and complained of inability to pick up small objects.

Comment

These two cases illustrate the difficulties of attaining a satisfactory result unless the entire transverse carpal ligament is severed. Both of these wrists were decompressed through a transverse incision and the distal fibers of the transverse carpal ligament were probably not severed at the initial surgery. The time interval of seven years between the two operations in case number two is probably the reason for the final unsatisfactory result in this case. The compression was of such long standing that there will probably be no adequate return of function to this patient.

The results from surgery have generally been quite good. Phalen[7] reports that 85 patients out of 112 regained normal sensation. Seventy-six out of 112 cases in which there was thenar atrophy achieved normal musculature. He reported one case in which there was progression of thenar atrophy postoperatively. Reoperation in this patient revealed that the ligament had not been completely severed.

Summary

Two cases of carpal tunnel syndrome are presented in which operative failure resulted because of incomplete severance of the transverse carpal ligament.

BIBLIOGRAPHY

1. Arlet, J., Ficat, P., Malbose, J.: Lesions of the Carpal Tunnel Tenosynovial Sheath in the Carpal Tunnel Syndrome, *Rev. Rheum.* 33:194-199, 1966.
2. Cracchiola, A., Marmor, L.: Peripheral Entrapment Neuropathies, *JAMA* 204:431-434, 1968.
3. Kaplan, E. B.: *Functional and Surgical Anatomy of the Hand*, Lippincott, Philadelphia, 1953, pp. 162-163.
4. Lettin, A. W. F.: Carpal Tunnel Syndrome in Childhood, *J. Bone and Joint Surg.* 47-B:556-559, 1965.
5. Marie, P., Foix: Atrophe isolee de l'eminence thenar d' origine nevritique. Role du ligament annulaire anterieur du carpe dans la pathogenie de la lesion, *Rev. de Neurologique, (Paris)* 21:647-649, 1913. (Quoted by Phalen.[6])
6. Phalen, G. S., Gardner, W. J., LaLonde, A. A.: Neuropathy of the Median Nerve due to Compression Beneath the Transverse Carpal Liga-

ment, *J. Bone and Joint Surg.* 32-A:109-112, 1950.

7. Phalen, G. S.: The Carpal Tunnel Syndrome, *J. Bone and Joint Surg.* 48-A:211-228, 1966.
8. Putnam, J. J.: A series of cases of paresthesia, mainly of the hands, of periodical occurrence, and possibly of vasomotor origin, *Arch. Med.* 4:147, 1880. (Cited by Tanzer.[9])
9. Tanzer, R. C.: *Reconstructive Plastic Surgery*, Vol. IV, Saunders, Philadelphia, 1964, ed. by Converse, pp. 1787-1794.
10. Vignon, G., Megard, M., Vauzelle, J. L., Goutelle, A., Chatin, B.: The Carpal Tunnel Syndrome and Multiple Myeloma. A Report on a Patient Treated by Surgery, *Rev. Rheum.* 33:486-489, 1966. ◄

1412 Franklin St.
Michigan City 46360

I.U. School of Medicine Postgraduate Courses
(Division of Postgraduate Medical Education)

DATE	COURSE TITLE	LOCATION	COURSE DIRECTOR
Dec. 11	Office Gynecology	I. U. M. C.	Carl Huber, M.D.
Jan. 15	Acute Cardiology	Marion County General Hospital	Charles Fisch, M.D.
Feb. 12	Emotional Problems of Young People	Ball State University, Muncie, Ind.	Wayne G. Pippenger, M.D.
Feb. 12	Modern Therapy of Cancer	I. U. M. C.	Robert Rohn, M.D.
Feb. 19	Management of Pediatric Handicaps	I. U. M. C.	Morris Green, M.D.
Mar. 5	Therapy of Chronic Obstructive Lung Disease and Bronchitis	I. U. M. C.	Roy Behnke, M.D.
Mar. 13/14	Community Neurology	I. U. M. C.	Joseph Green, M.D.
Mar. 19, 20, 21	Electrocardiography for Physicians	I. U. M. C.	Donald Close, M.D.
Mar. 24, 25, 26	Electrocardiographic Interpretation of Arrhythmia	Marion County General Hospital	Charles Fisch, M.D.
Mar. 26	Ophthalmology for the General Practitioner	I. U. M. C.	Fred Wilson, M.D.
April 2	Management of Congenital Anomalies of Skin and Soft Tissue	I. U. M. C.	James Bennett, M.D.
Apr. 15, 16, 17, 18	Radiology of Trauma	I. U. M. C.	John Campbell, M.D.
Apr. 13-Apr. 27	Anatomical and Clinical Otolaryngology	I. U. M. C.	David Brown, M.D.
April 23	Management of Common Dermatologic Conditions	Marion County General Hospital	Victor Hackney, M.D.
May 13/14	Indiana Multidisciplinary Child Care Conference	Stouffer's Inn	Morris Green, M.D.
May 22	Psychiatry in Everyday Practice	Elks Country Club, Sullivan, Ind.	Betty Dukes, M.D.

This series is intended to emphasize the importance of judicious selection and proper interpretation of newer laboratory procedures as applied to differential diagnosis of various diseases. It is edited by Leon L. Blum, M.D., Terre Haute.

Bone Marrow Examinations: Why, When and How?

LEON L. BLUM, M.D.
Terre Haute

BONE marrow examinations can furnish important information in many hematologic disorders but when improperly performed, without proper indications, they are worthless and may be misleading.

Prerequisites are a thorough clinical history, physical examination and study of peripheral blood.

A. *Conditions in which marrow studies are helpful:*
   1. Differential diagnosis of unexplained anemias, leukopenias or pancytopenias.
   2. Abnormal electrophoretic or immunoelectrophoretic pattern of monoclonal gammopathy.
   3. Diagnosis of certain macrocytic anemias (Schilling's radioactive B_{12} absorption test is now more valuable in the diagnosis of pernicious anemia).
   4. Abnormal peripheral blood findings suggestive, but not diagnostic of leukemia.
   5. Suspected blood dyscrasias on the basis of unexplained bone lesions, splenomegaly, hepatomegaly or lymphadenopathy.
   6. Obscure pediatric hematology problems.

B. *Conditions in which bone marrow studies are helpful when positive:*
   1. Fever of unknown origin (granulomatous, mycotic or parasitic diseases).
   2. Lipoid storage diseases (e.g., Gaucher's disease).
   3. Nucleated red cells in peripheral blood in the elderly adult (metastatic neoplasms?).

C. *Conditions in which marrow studies are rarely helpful:*
   1. Hemolytic anemias (peripheral blood studies more helpful).
   2. Hypochromic anemias (peripheral smears, serum iron studies, clinical history more useful).
   3. Chronic lymphocytic leukemia unless associated with severe anemia.
   4. Chronic granulocytic leukemia (alkaline phosphatase score of leukocytes more valuable in differential diagnosis of granulocytic leukemia from leukemoid reaction).

D. *Conditions in which marrow studies are contraindicated:*
   1. Disorders of hemostasis, such as hemophilia and deficiencies of various coagulation factors (coagulation profile of peripheral blood indicated).

E. *Technic:*
   Preferred site: Sternum for adults.
   Vertebral body or iliac crests for infants and small children.
   Aspiration: With heparin or EDTA-rinsed syringe:
   a. First few drops into a Petri dish containing

a few drops of EDTA or diluted heparin.

b. 1 cc. into a paraffinized tube containing anticoagulants as under a.

Preparations made:

a. Direct particle smears on coverslips (from Petri dish).
b. Imprints.
c. Particles for paraffin sections (much preferred to sectioning of the clot).
d. Concentrated smears after centrifugation from paraffinized tube. These smears are extremely useful for demonstration of Histoplasma organisms and for rapid evaluation of poorly cellular marrow.
e. Specially stained sections or thick smears for evaluation of iron storage.

F. *Pitfalls in the evaluation of marrow studies:*

1. Marrow aspirations performed without proper indications.
2. Inadequately obtained or poorly prepared material.
3. Inadequate clinical history.
4. Previous treatment with antianemic drugs or "shotgun" preparations.
5. Incomplete peripheral blood work-up.
6. "Dry taps." If no marrow aspirated with proper technic, surgical trephine biopsy is indicated (myelofibrosis, malignant neoplasms, etc.). ◄

1505 N. Seventh St.
Terre Haute 47808

About Our Cover

YOUR chances of being killed in an auto accident increase FIVE times if you are thrown from the car.

Of the 53,000 persons killed in traffic accidents in 1967, some 35,000 were drivers or passengers in automobiles. From 8,000 to 10,000 of those lives could have been saved if they had only fastened their seat belts.

Seat belts are the best low-cost safety feature available for a car, yet many people fail to install and use them. They seem to feel that because they don't drive fast or take long trips, they have no need for seat belts.

But the truth is that more than half of the accidents causing injury or death involve speeds of less than 40 miles per hour. And three out of four traffic deaths occur within 25 miles of home. If that doesn't convince you to "not be caught dead sitting on your seat belt," ONE out of every FOUR cars will be involved in a traffic accident this year!

Seat belts won't stop accidents — but they *will* reduce deaths and injuries.

This month's cover is one of the ads of a seat belt safety campaign, the 23rd year The Advertising Council has sponsored a traffic safety campaign for the National Safety Council. It is the hope of the National Safety Council that the constantly repeated question, "What's Your Excuse?" will persuade the "believing non-users" to face up to reality and decide that too many people with too many excuses end up in too many hospitals (or funeral homes).—J.F.S.

The Arthritis Foundation salutes the thousands of dedicated physicians who volunteer their services in the nation's fight against crippling arthritis.

The Arthritis Foundation is the sole national voluntary health agency committed to conquering the rheumatic diseases. It provides the means for dynamic partnership between physicians and laymen to marshal leadership and resources toward the solution of this major national health problem.

The Arthritis Foundation looks forward to rapid growth with increasing opportunity for physicians to participate in the arthritis movement. For further information about The Arthritis Foundation and its programs write to the Foundation chapter in your community or to the Medical Department, Box 2525, New York, N.Y. 10001.

Floyd B. Odlum
Chairman of the Board

William S. Clark, M.D.
President

Donald F. Hill, M.D.
President of the American
Rheumatism Association Section

William E. Reynolds, M.D.
Medical Director

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 1802 North Illinois Street, Indianapolis, Ind. 46202.

Associate Editors: A. W. Cavins, M.D., 221 South Sixth Street, Terre Haute; Lall G. Montgomery, M.D., Ball Memorial Hospital, Muncie; David A. Bickel, M.D., 515 Odd Fellows Building, South Bend; Samuel R. Mercer, M.D., 702 Medical Center Bldg., Fort Wayne; I. W. Wilkens, M.D., 1743 Shelby St., Indianapolis.

Editorial Board:	Term Expires
Alvin J. Haley, M.D., Fort Wayne	Dec. 31, 1968
Wei-Ping Loh, M.D., Gary	Dec. 31, 1968
Jack W. Hickman, M.D., Indianapolis	Dec. 31, 1969
Frank H. Coble, M.D., Richmond	Dec. 31, 1969
Jene R. Bennett, M.D., South Bend	Dec. 31, 1970
W. D. Snively, Jr., M.D., Evansville	Dec. 31, 1970

Assistant Editor: Jackie Freers Stahl
Business Manager: James A. Waggener
3935 N. Meridian, Indianapolis, Indiana 46208.

New Method Tried in Personal Injury Suits

A new way of compensating the victims of personal injury auto accidents is being tried in two heavily populated districts.

The present system of trial by law is unsatisfactory, at least in part, because of the great delay in and the considerable cost of suits in court. Some jurisdictions are so overloaded with personal injury suits as to postpone the final verdict for as long as several years.

The new plan is called "Guaranteed Benefits." It is being given a trial run on a large scale in several populous counties, both in New York and Illinois.

"Auto accident victims who have valid bodily injury claims against the participating companies (10 in Illinois, 14 in New York) are being offered up to $12,500 in "no red tape" payments. They will collect up to $5,000 for medical expenses incurred within one year of the accident, and will be offered up to $7,500 in optional benefits for wage losses and other damages, including physical impairments," says the current issue of the *Journal of American Insurance*.

Those who accept such an offer receive prompt payment for their known losses, plus the assurance that they will be paid more in the future if their injuries do not heal as expected. Those who are not satisfied with the offer may take their chances on a settlement based on proving that the other driver is legally responsible.

"The insurer of the driver responsible for the accident will contact the injured person as quickly as possible and offer to pay his medical expenses, up to $5,000, without red tape and as the medical bills are incurred. The injured person doesn't have to make any promise or sign a release to receive these medical benefits," the article states.

In addition, the injured person has an option of accepting an additional package of optional or elective benefits in exchange for an oral agreement that the amount is satisfactory and he won't make any further claim against the other driver.

The Guaranteed Benefits payments are limited to $12,500, unless the policy involved has a lower limit.

About 3,000 bodily injury claims will be processed in each state. The results will be computerized and researched to find whether the Guaranteed Benefits package will be attractive to injured people, and if not, why not.

Another purpose is to gather data on how much it would cost to extend Guaranteed Benefits to all accident victims, regardless of fault. No payments are made, under the trial plan, if the claimant is held to be responsible for the accident. This is against insurance law and contrary to insurance policies.

The companies involved want to know the cost of providing Guaranteed Benefits to all those injured with the possible exception of flagrant offenders such as hit-and-run drivers. If the plan proves to be feasible, it cannot be adopted as applying to all injured until the insurance laws are rewritten.

If the Guaranteed Benefits plan provides better compensation to the injured at a saving for the insurance carriers, it will have great merit. Changing the law would be a small price.

PMA Comments on Second Report of HEW Task Force

C. Joseph Stetler, president of the Pharmaceutical Manufacturers Association, commented recently on the Second Interim Report of the HEW Task Force on Prescription Drugs.

He credited the Task Force with an earnest attempt to solve a complex problem, but pointed out several inconsistencies and inaccuracies in the factual part of the report.

One omission was the failure to recognize the significance of declining prescription drug price levels and the fact that drugs are accounting for a gradually decreasing share of the medical care dollar.

Whereas the report charged that competition in the industry is confined to quality and therapeutic value, Mr. Stetler emphasized that price is an equally active factor. Many drug categories are manufactured and distributed by many different companies with resulting price competition and lowering of prices.

The report's criticism of combination products is not valid, in the opinion of the PMA, since the combinations are often low in side-effects and provide competition to dominant products. And besides being convenient to all concerned, the combination products are easy to handle and the cost, especially at the retail level, is considerably less.

Mr. Stetler also disagreed with the report on the matter of the orientation of industry research. The Task Force indicated that only 20% of the research and development funds were directed to new "single entity" chemicals and that most research was devoted to work on congeners and combination products. Mr. Stetler stated that the bulk of the research was actually assigned to the discovery and development of new agents of the "single entity" variety.

The report states that the drug industry does not want "any government interference." The PMA and all its members, reports Mr. Stetler, have been the moving force for the establishment of strict regulatory standards, good manufacturing practices and quality control. It is one of the most regulated of all industries, and, in fact, the PMA has, in the past, lobbied vigorously for more budgetary support for the FDA and its regulatory functions.

Mr. Stetler pledged the continuing cooperation of the pharmaceutical industry in supplying in-depth comments on the recommendations presented and in providing assistance in the conduct of further studies which were suggested in the report.

Editorial Notes...

The treatment of obesity has its own professional organization. The Research Institute of Metabolism and Nutrition has been formed by physicians engaged in the practice of treating obese patients. The Institute's number one objective is to "support and assist the practicing physician in his unceasing efforts to upgrade medical care of the obese patient." Research will be stressed. Weight reduction of large magnitude should not be accomplished solely by dieting since almost half the overweight patients have some major disease in connection with, or in addition to, their obesity. The Institute says: "The incidence of significant disease in overweight people, as uncovered by studies, is one more reason why such patients should begin any reducing effort by going to a doctor or clinic for a medical checkup."

There is some doubt, on the part of the American Institute of Laundering, as to the sterilizing effectiveness of a new system of bed linen laundering. Some hotels and motels use no-iron bed linens and launder them at 100 degrees for five minutes with a so-called bacteriostatic detergent. It may be that the old-fashioned custom of ironing the wash was what made it bacteriologically clean. The Institute has found that the new method leaves dangerous numbers of bacteria. In fact, the independent laboratory found that the detergent did not add anything to the de-germing process. Increasing the temperature of the wash water and the time of the laundering increased serially the effectiveness of the laundry process as measured by bacterial counts.

Dr. Harry A. Cochran, Jr., vice president and chief medical director of The Lincoln National Life Insurance Company of Fort Wayne, discussed the insurability of diabetics and people with heart ailments recently at the AMA meeting in San Francisco. The majority of such patients can be offered insurance coverage if a clear picture of physical condition is obtained. Usually, Dr. Cochran says, the doctor's information places the patient in a better risk group than does information obtained from the applicant.

The American Hospital Association's announcement that hospital outpatients are increasing is no news to doctors, but the documentation for it is interesting. The new peak of 9,589,478 outpatient visits was reached in April of this year—an increase of 10% over the same month in '67. The ratio of outpatients to inpatients varies from 2.5 to 1 up to 5.5 to 1. The bigger the hospital, the larger the proportion grows.

Life insurance companies are tending to acquire less medical information on applicants and some day life insurance may be written without a physical examination. Ardian Gill, actuary of the Mutual Life Insurance Company of New York, in speaking at the AMA sponsored Congress on Medicine and Insurance, said his company was obtaining medical examinations on only one-third of their applicants, and are obtaining additional information from physicians and hospitals only five percent of the time. The modern thought is that by spending less on investigation, the insurers will be able to save enough to absorb the losses. ◄

P. J. V. CORCORAN, M.D.

President

Indiana State Medical Association

1968-69

Dr. Patrick J. V. Corcoran was inducted as president of the Indiana State Medical Association during the annual convention last month in Fort Wayne.

Dr. Corcoran succeeded Dr. G. O. Larson after they both had spent an exceedingly busy and fruitful year as president-elect and president of the association.

Born in Great Falls, Montana, Dr. Corcoran first came to Indiana to attend Notre Dame University. He was a Fellow in Pathology at Northwestern University Graduate School and was awarded the Master of Science Degree in 1938.

Dr. Corcoran received his M.D. degree from Northwestern in 1939 and then served his internship and a three-year Fellowship in Internal Medicine at St. Louis University Group of Hospitals and was granted a Master in Internal Medicine degree in 1943. He has practiced his specialty of internal medicine in Evansville since 1943.

A diplomate of the American Board of Internal Medicine, Dr. Corcoran is also a Fellow of the American College of Physicians and a Fellow of the American College of Cardiology. In 1958-59, he served as president of the Vanderburgh County Medical Society.

Other medical activities in Evansville have included the presidency of the St. Mary's Hospital medical staff and chief of its medical section and chief of medicine of Deaconess Hospital. He was a member of the City-County Health Board for three terms.

Dr. Corcoran's assignments in the state association began with membership on the Committee on Public Policy and Legislation in 1948, followed by membership on the Commission on Legislation until 1963. He was on the Committee on Heart Disease in 1953 and was a member and vice-chairman of the original I-HOPE Board when it was organized in 1960.

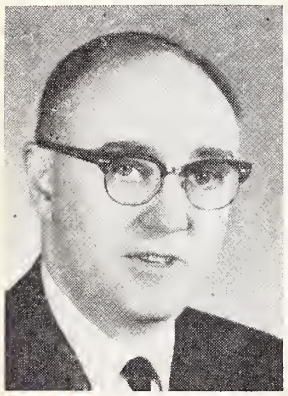
After serving two terms as alternate councilor, he was elected councilor from the First District in 1962. He was re-elected in 1965 and served until 1967 when he was chosen as president-elect. Dr. Corcoran was a member of the Council Committee of Business Consultants for The Journal and was chairman of the Council Committee on Economics and Fiscal Matters.

Dr. Corcoran and his wife, the former Margaret Booth, have five children — daughters Laura Ellen, a junior at St. Louis University; Sheila, a freshman at the University of Evansville; Monica and Val, both students at Memorial High School in Evansville and a son, Timothy Christopher, now two-and-a-half.

President's Page

ORGANIZED MEDICINE: ITS ROLE AND FUNCTIONS

The Medical Sociey is the physician's primary professional organization; it should enroll all doctors concerned with health care. Every member should be adequately represented; there should be no second-class members. It must deal with all the proper interests of the public and of the profession equitably, which may involve delegating specific chores to particular groups such as the hospital staff, specialty societies, teaching faculties or surveillance committees.



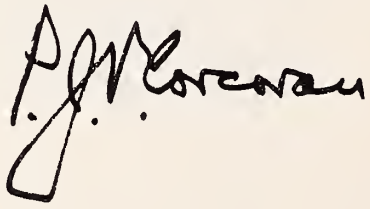
The Medical Society has four roles:

PROFESSIONAL. It embodies the profession of medicine — it speaks or acts for medicine, when dealing with matters in which we have specialized, authoritative, usually first-hand, knowledge or expertise. In this, we have the position of primacy. We should take the initiative whenever we perceive a need, or when we are requested. As a corollary, we should respect the precedence of other professions whenever they carry out their appropriate role; clergy, lawyers, economists, insurance executives, public relations experts or others deserve the esteem in their field which should be given to us in ours.

SOCIO-ECONOMIC. Socio-economic problems have preoccupied us recently. A major one currently is the effective delivery of health care, which means quality service equally accessible to everyone under ordinary circumstances. As new techniques become available, they must be used or adapted to the best of our ability. Manpower shortages require resourceful solutions which may involve education, updating of our own skills, delegation of duties to related professionals or to paramedical personnel or reassessment of our own responsibilities and limitations.

SELF-INTEREST. Another category has to do with matters of our own self-interest. These may be personal or economic, or related to prestige, convenience or medical education. Here we represent our profession regarding the well-being of its members, much as does a guild or trade association. In this we should be matter-of-fact, candid and objective. The public will be more inclined to respond to us fairly when we "tell it like it is." This is a legitimate and proper function and we should not be coy or apologetic, because it is necessary and essential if the profession is to be fully effective.

CIVIC. We have a civic role of much greater relative importance than our numerical proportion in the community would indicate. People generally respect us, both as individuals and as a group. There are many activities in which we should participate, depending on our qualifications. As doctors, we should truly be teachers and leaders. We can influence and lead to an exceptional degree. Our training and our special point of vantage peculiarly ordain us to play a major part in setting the moral tone and the social fabric of our environment. We are derelict if we shrink from this—an obligation which is reciprocal to our opportunity.



Let's be specific about Campbell's Soups... and *reducing diets*

There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N.J. 08101

In childhood

Warnings: Lomotil should be used with caution in patients taking barbiturates and with caution, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a Federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur, signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise. Respiratory depression and coma may occur with overdosage.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

diarrheas...

- careful supervision
- electrolyte replacement
- specific anti-infective therapy

and...

LOMOTIL®

TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride ..... 2.5 mg.
(Warning: May be habit forming)
atropine sulfate .....0.025 mg.

LOMOTIL, in conjunction with specifically indicated medical management, may be lifesaving in children with severe diarrhea.

Lomotil lowers the excessive intestinal propulsion characteristic of diarrhea. This reduction of precipitate intestinal flow allows a normal or more nearly normal reabsorption of fluid and electrolytes and counteracts the dehydration so hazardous to children.

Moreover, eight years' experience has demonstrated that Lomotil controls diarrhea with a minimum of unwanted secondary actions.

Senra del Valle and his associates[1] conducted a study of 477 children with diarrhea, most of whom were hospitalized with the disorder. Lomotil, used in 407 of the children, shortened the duration of the diarrhea.

Grinszpan, Goldstein and Divito[2] used Lomotil in 20 children with diarrhea and also reported a prompt disappearance of diarrhea. Harris and Beveridge[3] in a double-blind study of 50 children with diarrhea, however, found no clear pattern to suggest that Lomotil influenced the course of the condition.

Michener, Brown and Turnbull[4] added evidence supporting the beneficial effects of Lomotil in 80 children, concluding that Lomotil was highly useful in controlling abdominal cramping, diarrhea and hypermotility.

Children: Total Daily Dosage

3-6 mo. . . . ½ tsp.* t.i.d. (3 mg.)
6-12 mo. . . ½ tsp. q.i.d. (4 mg.)
1-2 yr. . . . . ½ tsp. 5 times daily (5 mg.)
2-5 yr. . . . . 1 tsp. t.i.d. (6 mg.)
5-8 yr. . . . . 1 tsp. q.i.d. (8 mg.)
8-12 yr. . . . 1 tsp. 5 times daily (10 mg.)
Adults: . . . . 2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

References:

1. Senra del Valle, A.; Linfante de Rufinelli, E. B.; Brumetti, E., and Rossi, R. H.: El chlorhidrato de difenoxilato en las diarreas infantiles, Sem. Med. (Buenos Aires) *127*:475-484 (Oct. 4) 1965. 2. Grinszpan, I. L.; Goldstein, A., and Divito, J.: El chlorhidrato de difenoxilato en las diarreas infantiles, Sem. Med. (Buenos Aires) *125*:758-763 (Aug. 27) 1964. 3. Harris, M. J., and Beveridge, J.: Diphenoxylate in the Treatment of Acute Gastro-Enteritis in Children, Med. J. Australia *2*:921-922 (Nov. 27) 1965. 4. Michener, W. M.; Brown, C. H., and Turnbull, R. B., Jr.: Ulcerative Colitis in Children. II. Medical and Surgical Therapy, Amer. J. Dis. Child. *108*:236-242 (Sept.) 1964.

SEARLE

Research in the Service of Medicine

Lilly

Eli Lilly and Company
Indianapolis, Indiana 46206

200486

The Woman's Auxiliary

REPORTS TO ISMA

"Accent on Youth" is the theme Esther Long chose for her year as president of the national auxiliary. At the 25th Annual Fall Conference for State Presidents and Presidents-Elect just held in Chicago, she presented a new action program to end TV and movie violence.

Will you see that the Woman's Auxiliary of your society helps implement the program in Indiana? At the state level we are hard at work to spark interest and enthusiasm in this seven point program. May we count on the cooperation of you and your wives to alert your community to an effective plan of action?

I do not need to tell you that the violence of our times is a threat to the well-being of every person in our nation—and especially our young people. Violence kills and maims as surely as does disease. It can irreparably blight our lives and darken the future of every young person unless we act to stop it.

As *McCall's* magazine recently pointed out, "Women can stop the outpouring of violence and sordidness on our television screens and in the motion-picture theaters." This is only one factor in the brutalization of our national life, but it is a factor we can do something about—*now*.

Much is being written about the situation—but not enough action is being directed at the sources of decision on programming and content. I propose that every auxiliary engage in an action program directed where it can do the most good. Here is what auxiliaries can do:

1. Appoint action committees in your auxiliary to call personally on:
   - Managers of all TV stations in your area.
   - Owners or managers of all local movie chains and individual theaters.
   - Heads of local advertisers on TV.
2. Form joint action groups with PTAs, Leagues of Women Voters, church women's groups, teachers.
3. Set up a viewing and screening schedule to monitor all shows, keeping records of the degree, frequency, time, etc., of violence on each station and in each theater. (Be careful *not* to give any appearance of censorship or of boycotting any given station or theater—this is not the tack we should take.)
4. Feed this information steadily to the local TV critics, editorial writers and movie reviewers as background for their commentaries.
5. Launch letter-writing campaigns to the presidents of national advertisers, TV networks, advertising agencies and movie producers. Emphasize the auxiliary's concern for sound health education; avoid abusive language or threats of boycotts. Here are some addresses you can write to:

   Julian Goodman, President
   National Broadcasting Company
   30 Rockefeller Plaza
   New York City

   Frank Stanton, President
   Columbia Broadcasting System
   51 West 52nd Street
   New York City

   Leonard Goldenson, President
   American Broadcasting Company
   1330 Avenue of the Americas
   New York City

   Jack Valenti
   Motion Picture Association of America
   522 Fifth Avenue
   New York City

6. Support community forums on violence and urge other women's groups to participate.
7. This is an election year. Send letters to the newly-elected president and state representatives. There couldn't be a more opportune time to bring action to bear so as to affect national policy.

Let's make a valiant effort in Indiana to cope with violence!

Betty Kephart

Private practitioners came under social security in 1965. In addition to earning retirement and survivors protection, they may also have earned disability protection. Work credits could have been accumulated before 1965 through internships, residencies, military service and other covered employment. This article discusses the disability program, and how recent changes to the law affect the physician and his patients.

The Social Security Disability Program

How Recent Amendments Will Affect The Physician And His Patients

E. B. HAGGARD, M.D.
*Indianapolis**

IF you pay—or if you have ever paid—social security contributions on your earnings, you and your family may be covered by the social security disability program.

In the disability program, a worker under 65 may be eligible for monthly payments if he is disabled because of a severe physical or mental impairment which has lasted (or is expected to last) a year or longer. He must be unable to do not only his usual job, but any work in keeping with his age, education and experience.

The disability program was improved by legislation that became law early this year. As a result of an increase in benefits under the new social security amendments, monthly payments can amount to as much as $189.90 for a disabled worker and $395.60 for a family. In forthcoming years, maximum monthly benefits will be even higher.

To be insured for disability purposes, a person disabled when he is 31 or older needs to have worked under social security for at least five of the 10 years preceding the onset of disability. For younger workers, who may not have had the chance to work this long, the work requirement ranges down with age to as little as one and a half years of work credits.

Under the new amendments, an additional group of people—disabled widows (including certain surviving divorced wives) and disabled dependent widowers of insured workers—can become eligible for reduced benefits at 50 or older, even though they themselves never worked. The disability must occur before—or within seven years after the spouse's death—or, in the case of a widow caring for a child entitled to benefits, within seven years after her benefits as a mother end. Factors such as age, education and previous work experience are not considered in deciding whether a widow is disabled (as they may for a disabled worker).

Benefits begin with the seventh full month of disability. (A six-month waiting period is required by law.) Payments can last as long as the disability continues. At 65, payments to disabled workers are converted into retirement benefits without any change in amount.

Helping Your Patients

Many physicians routinely advise any patient who they think might qualify for disability benefits to consult his social security office. Such advice can be a great service to the patient. Since disabled patients are often having financial difficulties, your suggestion that they file may result in their getting urgently needed funds.

The people in any social security office can tell a claimant what the eligibility requirements are and can help him apply for benefits. If a person is unable to come to the office because he is homebound or hospitalized, a social security representative can arrange to visit him.

Up to the present the most frequent causes of disability have been arteriosclerotic and hypertensive heart disease, emphysema, schizophrenic disorders, pulmonary tuberculosis, rheumatoid arthritis and osteoarthritis.

Reporting Data

When a patient applies for dis-

* Chief Medical Consultant, Disability Determination Section, Indiana Vocational Rehabilitation Division, 932 Illinois Bldg., Indianapolis 46204.

ability benefits, he is expected to furnish reports from his treatment sources for use in evaluating his claim for disability benefits.

Disability decisions under the social security program are made by an evaluation team consisting of a physician and a lay disability evaluation specialist. The team works in an agency of the state in which the applicant lives—in Indiana, at the Disability Determination Section of the Vocational Rehabilitation Division.

Typically, the evaluating physician is a private practitioner serving the agency on a part-time basis. He reviews the reports from physicians and hospitals and, in conjunction with the non-medical member of the team, decides whether the applicant's impairment is disabling under the law. The evaluating physician neither sees nor examines the patient. He depends entirely on the evidence reported by you and others who have examined or treated the applicant.

Experience has shown that the extent of a patient's disability can be determined largely on evidence from his own physician's records. By giving a detailed report of objective data in your files, you can help speed the decision on your patient's claim. On the other hand, long delays can result if the physician responsible for evaluating the evidence must write back to you or seek from other sources medical information about symptoms, signs and laboratory findings that you may already have in your files.

To be most helpful, report the same information that you would send any colleague to give him a complete medical picture of the patient. This report should contain not only a diagnosis, but also a complete history, results of physical examination and relevant diagnostic tests.

You may wish to save time in preparing the report by enclosing photocopies of pertinent portions of the patient's chart, including laboratory reports, electrocardiograms, x-rays, hospital discharge summaries and the like. Originals are welcome and will be promptly returned if requested. Under the law, your patient—not the Government—is responsible for providing the initial medical evidence in support of his claim.

Sometimes more medical evidence is needed for an evaluation than is available on the patient's chart. In this situation, the physician evaluating the claim may ask you to perform the needed tests and examinations at Government expense, or he may find it necessary to refer the patient for an independent consultative examination, also at Government expense. When the latter is done, the consultant's report can be sent to you if you wish.

"Childhood Disability"

In addition to covering disabled workers and disabled widows, the social security program has a provision for "childhood disability" benefits—a somewhat anomalous title since these benefits are paid after the person reaches 18. Ordinarily, children cannot get social security benefits as dependents after reaching 18 unless they are full-time students, and then only until they reach 22. But under the childhood disability provisions, a person continously disabled since before reaching 18 can be eligible for benefits after he reaches 18.

Childhood disability benefits are payable when the beneficiary's parent covered under social security dies or becomes entitled to retirement or disability benefits. Benefits can continue as long as the "child" lives if he remains disabled. He need not himself have worked under social security.

Since 1957 the childhood disability program has awarded monthly benefits to nearly 300,000 persons too handicapped to be self-supporting. Over 65% of beneficiaries under this program suffer from some form of mental deficiency. Other prevalent conditions of beneficiaries under the program include cerebral palsy, schizophrenic disorders and epilepsy.

Motivating Rehabilitation

In addition to paying cash bene-

SOCIAL SECURITY DISABILITY PROVISIONS AT A GLANCE

* Benefits go to disabled workers under 65 and their dependents.
* A disabled worker needs credit for a certain amount of work under social security. If he is disabled before age 31, he can now be eligible for benefits with credit for fewer years of work than before.
* Widows and dependent widowers who are 50 or older can receive reduced benefits based on disability, if the spouse was covered under social security.
* Persons handicapped continuously since before 18 may get benefits under the "childhood disability" provisions when a parent covered under social security dies or becomes entitled to retirement or disability benefits.
* Benefits are payable if the disability has lasted, or is expected to last 12 months or longer or result in death.
* Benefits generally begin with the seventh full month of disability.
* Benefits for a worker are the same amount that retirement benefits would be if he were 65.
* All applicants are considered for vocational rehabilitation services.

fits, one of the main goals of the disability program is to help restore as many applicants as possible to gainful work. At the time your patient's claim is being evaluated, he is also being considered for possible services by the Indiana Vocational Rehabilitation Division. Such services—which include medical rehabilitation, counseling, teaching of new employment skills, training in the use of prostheses and job placement—are usually financed from state-federal appropriations.

Additional resources are also provided through social security trust funds to pay the costs of rehabilitating certain disability beneficiaries. This should save social security money because in the long run the cost of rehabilitating beneficiaries is less than the expense of paying them benefits.

As the patient's physician, you are in a good position to reinforce this interest in returning to productive work, if this is feasible. Incorporated in the social security disability program are several incentives for rehabilitation that doctors often cite to help motivate patients.

For instance, a worker on the disability rolls who returns to work despite a severe impairment may continue to get monthly benefits for as long as a year while he tries to reestablish himself as self-supporting. If at the end of this period he shows himself able to work, benefits stop. Benefits continue, however, if his attempt is unsuccessful. This helps overcome the anxiety of a beneficiary who fears all income will be cut off if he fails in his attempt to work.

As a further incentive, former beneficiaries who have recovered or returned to work get special consideration should they again become disabled. If disability recurs within five years (seven years for widows), they need not go through another six-month waiting period before benefits resume. ◄

The New State Board Examination

*MERRITT O. ALCORN, M.D.**
Madison

For many years there has been concern over the essay type of examination used by the Indiana Licensing Board because of the small volume of information covered, difficulty in impartial grading and delay in obtaining grades.

In recent years there have been as many foreign graduates taking the Indiana examination as United State graduates, although, there are very few foreign graduates taking postgraduate training in this state. Many of them come from Illinois and Ohio and return by reciprocity to these states if they pass the Indiana examination. This puts Indiana in the uncomfortable position of licensing physicians for other states which give a more comprehensive type of examination.

The new FLEX examination (Federation Licensing Examination) is prepared by the Federation of State Medical Boards from the National Board of Medical Examiners Examination Bank. Questions are carefully selected to evaluate ability to practice medicine. The examination is in three parts, each part requiring one day. The first is basic science material, the second portion covers clinical subjects and the third part is a practical application of knowledge examination with film strips of patients and other methods designed to measure ability to examine, diagnose and treat patients.

* President, Indiana State Board of Medical Registration and Examination.

This examination was first given in June, 1968, by seven states, including Illinois and Ohio. The reaction by all boards involved was one of enthusiasm.

The President's Commission on Health Manpower has expressed its concern over the amount of licensing of graduates of inadequate medical schools. This group has specifically recommended that the National Board Examination be used to evaluate all foreign graduates; however, Dr. John Hubbard, President of The National Board of Examiners, has pointed out that the Federation Examination is specifically designed for licensing and would be the appropriate examination. This is apparently acceptable and now it remains a question of whether the states are able to go to this level of examination or whether federal licensing legislation will be necessary.

The Indiana State Medical Board has unanimously agreed to use this examination and has received endorsement by the Indiana State Medical Association and the administration of the Indiana University School of Medicine. The only obstacle remaining is that the Medical Practice Act must be changed because it specifies an examination fee of $25.00 and a fee of $75.00 is needed to cover costs of the Federation Examination.

The Indiana Board of Medical Registration and Examination is asking that this change be made by the 1969 Indiana General Assembly and needs the support of physicians throughout the state.

In the complex picture of moderate to severe anxiety...

there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl) 25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ

SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-170

Louie lost weeks with acute shoulder bursitis. That's a lot of pain, stiffness and tenderness...and also a lot of fish. It might have been different with **Butazolidin® alka**

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

If it doesn't work in a week, forget it

But please don't forget this:

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alka formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Painful Shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

(8) 46-070-8

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Butazolidin® alka Geigy

Capsules
100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

BU-6210

The Divorced Depressive: "Forty, Forgotten

"Had a large wedding."
"Had a fine home and family."

.Forlorn"

"Had a divorce."
"I'm a real loser,
and so are
the kids."

in depression

The loss of marital compatibility results in nearly 500,000 U.S. divorces each year.

Depression characterized by untold guilt feelings, grief and loneliness may follow.

When you diagnose depression, Tofrānil may be indicated for relief.

As maintenance therapy during the active phase of depression, Tofrānil can often help prevent relapse.

The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated. In patients with cardiovascular disease, thyroid disorders, increased intraocular pressure; in those receiving anticholinergics (including antiparkinsonism agents), thyroid medication or antihypertensive adrenergic neuron-blocking agents; and in those in their first trimester of pregnancy—the special precautions listed in the Prescribing Information should be carefully observed.

Toxic reactions severe enough to require discontinuation of Tofrānil are uncommon. However, for complete details, please refer to the complete Prescribing Information.

Turn page for brief summary of Prescribing Information.

Tofrānil® imipramine hydrochloride
Geigy

in depression

Tofranil® Geigy

imipramine
hydrochloride

Tofranil®, imipramine hydrochloride
Indications: Tofranil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of this agent and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before this drug may be substituted. Initial dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, it should not be used during the first trimester of pregnancy. Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy. Because of its anticholinergic effect, caution should be observed in prescribing the drug for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when this compound was added to the regimen. Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 years of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics and agitation (including hypomanic and manic episodes) which may require dosage reduction and/or addition of a tranquilizer or temporary discontinuation of the drug, epileptiform seizures, orthostatic hypotension and substantial blood pressure fall in hypertensive patients, purpura, transient jaundice, bone marrow depression including agranulocytosis, sensitization and skin rash including photosensitization, eosinophilia, and mild withdrawal symptoms on sudden discontinuation after prolonged treatment with high doses. Occasional hormonal effects (impotence, decreased libido, and estrogenic effects) may be observed. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those using anticholinergic agents (including antiparkinsonism drugs).
Outpatient Adult Dosage: Initially, 75 mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)R-46-850-C

For complete details, please refer to the full Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

TO-6757

GLEANED FROM THE BRITISH MEDICAL JOURNAL

JACK W. HICKMAN, M.D.
Indianapolis

Goldblatt Hypertension Amenable to Surgery

Correction of hypertension by reconstructive surgery on a narrowed renal artery or by resection of a unilaterally damaged kidney is rewarding and one of the striking therapeutic measures that surgery offers. Luke et al.[1] report their results on 27 patients from the Royal Infirmary in Glasgow. A number of important observations can be made from this paper. Only four of the 27 patients were over 50 years of age. It was discouraging to note that only one-third of the patients were noted to have an audible abdominal bruit preoperatively, since this physical finding is supposed to alert the clinician to suspect renal artery stenosis. It was reassuring to note that 25 of the 27 patients had some derangement of the I. V. P., so that this readily available procedure is valuable as a screening procedure. An isotope renogram and aortogram are the next logical diagnostic procedures to follow, and the authors feel that with these, it is not necessary to proceed with the more difficult differential renal function tests as prerequisites to surgery. Their surgical results were quite satisfactory and it was pleasant to note that they do not advise immediate surgery for all patients. They feel that the older patient with less severe hypertension should be tried on medical management even if renal artery stenosis is suggested by diagnostic procedures.

Daily Exercise Improves Obstructive Lung Disease

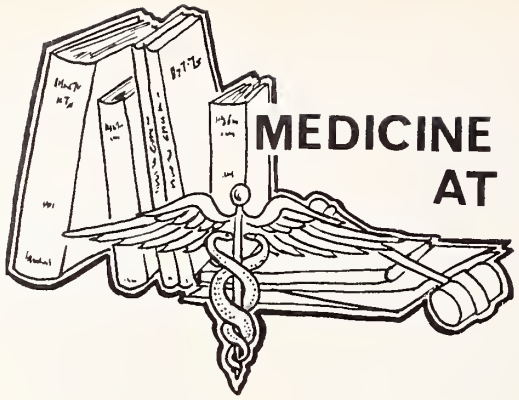
Generally, little if any emphasis has been placed on the value of physical training as part of the therapy of chronic obstructive lung disease patients in this country. Christie has described his results with such a program,[2] and concludes that it can be a valuable therapeutic asset. The eleven patients studied engaged in a 15-minute exercise period each day followed by a walk of one-half to one mile. Also included was a 5-minute period of stepping exercise roughly similar to a Master's test. All medical therapy for emphysema was continued as before. After ten weeks of this program, nine of the subjects experienced considerable improvement in well-being, exercise tolerance and physical working capacity. Pulmonary function tests demonstrated an increase in both maximum O_2 uptake and maximum tolerated ventilatory volume and a decrease in minute ventilation at submaximal work levels. Similar results have been described elsewhere, therefore, it should remind us that the complete therapy of chronic obstructive lung disease is not limited to drugs alone.

Propranolol Fails Double Blind Study

Since propranolol (Inderal) came on the cardiovascular therapeutic scene a short time ago, discussion has arisen regarding the proper indications for its use. It was stated that mortality from myocardial infarction might be cut in half by its use because of its anti-arrhythmia action and/or its ability to decrease myocardial oxygen requirements. Norris et al.[3] report a well done double blind study of the drug in 536 patients who had suffered fresh myocardial infarctions. In their study, the authors were unable to demonstrate any difference in the mortality rates between the control and treated groups. Furthermore no significant difference was found in the incidence of congestive heart failure, hypotension, continued chest pain nor major cardiac arrhythmias. The authors' conclusion that propranolol has no place in the routine management of myocardial infarction seems quite warranted.

REFERENCES

1. Luke, R. G., et al.: Results of Surgery in Hypertension Due to Renal Artery Stenosis, *Brit. Med. J.* 2:76-80, No. 5597.
2. Christie, David: Physical Training in Chronic Obstructive Lung Disease, *Brit. Med. J.* 2:150-151, No. 5598.
3. Norris, R. M., et al.: Trial of Propranolol in Acute Myocardial Infarction, *Brit. Med. J.* 2:398-400, No. 5602. ◄



Blinded Woman Awarded $550,000 In Drug Suit—A woman who became blind, allegedly as a result of taking Aralen, was awarded $550,000 by a jury in a federal trial court. The award was said to be the largest in Mississippi history against a drug company.

The woman began taking the drug in 1959, and she became blind two years later. Her attorneys contended that the drug company failed to give the medical profession timely or adequate warning of the drug's harmful effect.—News Release, New York, March 23, 1968.

Bequest to Defunct Hospital Upheld—A charitable corporation was held entitled to a bequest to a hospital operated by the corporation at the time of the testator's death, even though the hospital was no longer in existence when the estate was distributed. The bequest vested as of the testator's death, an Indiana appellate court ruled, and it was not divested by the cessation of the hospital's operations.

By a codicil dated December 29, 1955, the testator bequeathed one-half of the residue of his estate to a named hospital. No mention was made in the codicil of the charitable corporation that was the hospital's parent organization. The hospital was in full operation when the codicil was executed and when the testator died in April, 1957. Before the estate was settled and the bequests were distributed the hospital announced that it was closing on May 1, 1959, and it did close on that date.

At the time the estate was distributed, there was no such legal entity as the named hospital. However, the charitable corporation which operated the hospital was a recognized legal entity. A bequest to an institution in the name by which it is popularly known belongs to the legal entity which administers and receives the funds used in the institution's operations, the court said. Since the bequest was an outright bequest, it vested as of the date of the testator's death.

The argument that the testator intended to benefit only the named hospital where he had been treated, and did not intend any benefit to extend to the parent organization, was purely speculative on all sides. Since the bequest vested in the parent organization as of the date of the testator's death, it was not divested simply because one of its branches, the named hospital, subsequently went out of business. If the distribution had been made before the named hospital went out of business, the parent organization could have used the funds for other institutions that it operated, either while the named hospital was still open or after it was closed. This case demonstrates only too clearly, the court observed, that estates should be settled as promptly as possible.—*Indiana Masonic Home at Franklin v. Association of Franciscan Sisters of the Sacred Heart*, 235 N.E.2d 708 (Ind., April 2, 1968).

Confession of Mentally Defective Accused Inadmissible—In a prosecution for murder, the confession of an accused, who was mentally defective and a borderline feebleminded individual, was improperly admitted, the Indiana Supreme Court ruled. The confession was obtained without advising the accused of her right to council or privilege against self-incrimination and was made while the accused's will was overborne by the interrogating officers. Her conviction was reversed and the case remanded for a new trial.

The accused was questioned privately by two officers about the crime. A short time after one of the officers accused her of the crime, the accused admitted her guilt. She was then told that she was under arrest and that anything she said would be used in evidence against her. She was told that they would like her to tell them what had happened, but that she could have an attorney before making any statement. She said that she did not know any attorneys and then told the officers what had happened. The accused was 23 years old when she made the confession. Her education had ceased in the eighth grade when she was 16 years old. There was evidence that the accused was of substandard mentality and that she had a borderline I.Q.

The accused's mental weakness was such that the officers had little difficulty in eliciting the confession from her. It was elicited without the officers advising her of her absolute right to remain silent. They also failed to do their duty of advising her at the moment that she became a suspect that she had an absolute right to counsel. The confession was not the accused's free and voluntary act, but was obtained under circumstances where her will was easily overborne by the experi-

enced interrogating officers.—*Robbins v. State of Indiana*, 235 N.E. 2d 199 (Ind., April 5, 1968).

Physician Convicted in Weight-Reducing Scheme—A physician who had developed a weight-reducing theory based on the ingestion of safflower oil was held to have violated the Food and Drug Act by distributing safflower oil capsules as a cure for obesity. The physician's conviction was affirmed by a federal appellate court. Expert testimony as to the unsoundness of his theory was properly admitted, the court said.

The physician was the author of "Calories Don't Count", which was originally intended as an exposition of his theory that obesity could be cured, without restricting calorie intake, by regular ingestion of liquid oil containing polyunsaturated fats. He had been prescribing three ounces of liquid safflower oil per day for his patients, and this dosage appeared in the drafts and galleys of his book. Before the book was published, he became involved in an enterprise organized to distribute safflower oil capsules. To create a demand for the capsules, he prevailed upon his publisher to change the text to raise the recommended dosage to six capsules per day and to indicate that they could be obtained from the new enterprise. The labeling on the capsules tied them in with the book. The revised dosage contained only 1/15 as much safflower oil as the dosage originally recommended and, as the physician admitted, was worthless as a cure for obesity even in terms of his own theory.

The government was properly permitted to present expert testimony that the entire theory of the physician's weight-reducing diet was unsound. The evidence was admissible for the purpose of showing that the advertising claims made for the diet were scientifically false. An instruction that proof of error in the theory did not establish that the physician's intent was fraudulent would have been proper. However, the failure to give the instruction was not "plain error."

The jury found the physician guilty of eleven felonies and one misdemeanor conspiracy. There was no merit to the physician's contention that the Eastern District of New York was an improper venue for the misbranding counts, because the capsules were actually shipped from New Jersey to other states and the evidence proved that the shipments resulted from the physician's Brooklyn based activity.—*U.S. v. Taller*, —F.2d—(C.A.2, May 1, 1968).

Medical Society Ordered to Reinstate Physician—A physician removed from the membership rolls of a local medical society eight years ago was ordered reinstated because he had not been given notice of the charges or an opportunity to defend himself, as required by the society's constitution and bylaws. An Ohio trial court ruled that the physician's membership in the Academy of Medicine of Toledo and Lucas County was terminated "arbitrarily and capriciously" and directed the Academy to reinstate him.

Under the society's constitution, a physician against whom charges are brought must be notified of the charges, and a hearing must be held to determine whether his membership should be terminated. In this case, the physician received no notice, and no hearing was held.—News Release, Toledo, Ohio, March 13, 1968.

Unwanted Hospital Patient is Trespasser—A private hospital was granted an order requiring the removal of a patient who no longer needed hospital care but could be adequately cared for in a nursing home. The patient became a trespasser by remaining in the hospital after it had demanded that she be removed, a federal trial court ruled.

The patient's husband wished to have her remain in the hospital for the rest of her life. A private hospital has the right to accept or refuse any patient, the court said. It has a moral duty to reserve its accommodations for persons actually needing hospital and medical care and not to permit its facilities to be diverted to uses for which hospitals are not intended. To permit the patient to remain in the hospital would not be in the public interest.

Since the patient's husband was able and willing to pay whatever the hospital would charge if it were willing to retain her, an action for damages would not be an adequate remedy. The fact that the hospital had a remedy by way of an action for ejectment or an action for forcible entry and detainer did not detract from equity's power to grant relief by way of injunction. Neither of those actions would provide an adequate remedy.—*Lucy Webb Hayes National Training School for Deaconesses and Missionaries v. Geoghegan*, 281 F. Supp.116 (D.C., D. of C., June 28, 1967).

No Liability for Scar From Tetanus Test—A physician was held not liable for injury to a patient who required surgery after receiving a tetanus shot in the arm because the skin in the test area sloughed off. The operation left a ten-inch irregular scar on her upper arm. The trial court directed a verdict in favor of the physician.

After stepping on a nail, the woman consulted her physician later the same day. He took her history and tested her lower arm for reaction to tetanus, with a negative result. He then gave her a tetanus shot. The next day she developed a lesion on her lower arm, a delayed positive result of the tetanus reaction test. The skin in the upper arm test area sloughed, requiring surgery which left the scar. The patient had no history of unusual reactions to medical treatment, except for a fever she once ran after being given five

shots.—*Anderson v. Muench,* Cir. Ct., Cook Co., Docket No. 63C-7082 (Ill., May 2, 1968).

Physician Wins Suit for Fees—A physician won a suit to recover his fees from a patient who claimed that the physician had negligently reduced and cast a comminuted Colles' fracture of the right wrist, resulting in permanent stiffness of the wrist.

Four days after the physician reduced and cast the wrist, swelling developed. The patient consulted his son-in-law, also a physician, who referred him to an orthopedist. The orthopedist reset the wrist.

When the physician sent a $150 bill, the patient refused to pay, charging that the wrist had been improperly set, that the cast was too tight and of the wrong type, and that no anesthetic had been given. An Illinois trial court ruled that the physician had not been professionally negligent and ordered that the bill be paid.—*Dr. George S. Schwerin v. Edward Trainor,* Cir. Ct., Cook Co., Docket No. 62M-122679 (Ill., April 24, 1968).

Physician Loses Suit for Fall in Colleague's Home—A physician who fell in the home of a patient (also a physician) and fractured both bones in his lower right leg lost a suit against the patient for damages. The physician tripped on loose carpeting while making a house call to treat his colleague for bleeding ulcers. The physician alleged that as a result of the fall his foot had been injured so that he was unable to walk normally or locate the brake pedal on his car. However, evidence showed that since 1951 the physician had been treated for peripheral polyneuritis.—*Dr. Myer Keren v. Dr. Martin Fishkin,* Cir. Ct., Cook Co., Docket No. 62S-14020 (Ill., February 1, 1968).

$450,000 Awarded To Mother Injured During Operation—A 33-year-old woman, the mother of three sons, won a $450,000 settlement in a professional negligence suit against a hospital. The woman suffered severe brain damage when her oxygen supply was cut off during a gallbladder operation. Her survival is doubtful. The settlement was said to be one of the largest against a hospital in brain damage cases.

Pre-trial evidence showed that a plumber turned off the mother's oxygen supply pipe by mistake when he tried to repair an upside down nozzle on another pipe. Ten minutes elapsed before anyone noticed that the patient's blood was blue.— *Kaulbars v. Memorial Hospital of Dupage County,* Cir. Ct., Docket No. 67-24403 (Ill., May 24, 1968).

Fact Issues Raised in Childbirth Suit—A physician's motion for summary judgment was improperly granted in a suit for injuries resulting from his alleged negligence in delivering a child, a Florida appellate court ruled. His affidavit in support of his motion contained no expert explanation of the standard of care and its application to the facts, and was thus insufficient to establish that no genuine issues of material facts were raised by the pleadings.

The baby was born in a breech position. The umbilical cord was delivered when the baby reached the level of its belly. The physician noticed that the cord was not pulsating which meant that the baby was not getting oxygen from its mother. Since the baby's nose and mouth were not then delivered, there was no passage for air. The physician testified that, under those circumstances, he had no choice but to interfere in the birth by manipulating the baby, even though this involved a risk to its arms and brachial plexus. When the physician manipulated the baby's left arm in an attempt to deliver its head and create an air passage, he felt the left humerus snap.

It was alleged that the physician was negligent in delivering the child and in failing to take remedial steps with respect to the baby's arm immediately following its birth. In his affidavit, the physician stated that everything that he did was in accordance with accepted standards of practice in the community.

The reviewing court said that, although the physician's testimony as to how he delivered the baby and why he did so in that manner seemed reasonable, it did not explain the means normally followed by other qualified physicians in the community. The physician's statement that he acted in accordance with the community's approved standard, with no expert explanation of the standard and its applicability to the facts amounted to nothing more than a plea of not guilty.

With respect to the charge that the physician was negligent in his postnatal care of the baby, the physician's deposition contained conflicting statements as to what he did. The deposition was subject to an inference that he sought a consultation with an orthopedist and a pediatrician immediately after the birth. It was also subject to an inference that he delayed in seeking such a consultation. In addition, the deposition did not state what the approved standard of care in the community required the physician to do in the situation in which he found himself immediately after the baby's birth.—*Brooks v. Serrano,* 209 So.2d 279 (Fla., April 23, 1968).

Testimony Insufficient to Show Accident Caused Death—A beneficiary was not entitled to recover under the double indemnity provisions of a life insurance policy, despite the testimony of the policyholder's attending physician that the policyholder's death was caused by an accidental injury. A jury verdict in favor of the beneficiary was set aside by the U.S. Court of Appeals for the Fifth Circuit. The evidence

was insufficient to support the verdict.

The policyholder had suffered from asthma and pulmonary emphysema for ten years. He fell and broke his hip and underwent surgery for reduction of the fracture. The surgery was successful, but his lung condition worsened and he died several days later.

The policy provided for double indemnity benefits where death resulted from accidental injury, directly and independently of all other causes. It also provided that death would not be considered to have resulted from accidental injury if physical or mental infirmity contributed to the death.

All of the expert medical witnesses, other than the insured's attending physician, stated unequivocally that the insured's emphysema caused or contributed to his death. The attending physician testified that the "method" by which the insured died was the emphysema. He stated that the "cause" of death was the fracture, because it was the fracture and the surgery which set the respiratory failure in motion. That testimony was nothing more than a roundabout way of saying that the policyholder's emphysema contributed to his death, the court said. Reversing the judgment entered on the jury's verdict for the beneficiary, the court dismissed the suit.—*Prudential Insurance Company of America v. Schreffler*, 376 F.2d 397 (C.A. 5, April 25, 1967; rehearing denied, June 8, 1967).

Physician-Patient Privilege Not Affected by Marital Relation—The physician-patient relationship may exist between a physician and his former wife, the North Carolina Supreme Court ruled. The issue arose in a suit filed by the ex-wife against a paper company and its truckdriver for injuries sustained in an automobile accident. She sued for damages for alleged aggravation of a breast condition.

In a pretrial examination, the woman had testified that 20 years before the accident, when she had been married to the physician, she had had a small lump removed from her breast. She refused to disclose the physician's name and to state whether or not he had treated her for the breast condition.

There appeared to be no legitimate reason for her refusal to disclose that information, the court said. However, if the physician-patient relation had existed between the woman and the physician who was her former husband, any information which he acquired while attending her in his professional character was as fully protected as if they had not been married to each other.—*Furr v. Simpson*, 155 S.E.2d 746 (N.C., July 24, 1967). ◄

Finally...a salicylate superior to aspirin?

Not at all, Doctor...but

magan®

(magnesium salicylate, W-T)

should be considered for your arthritic and rheumatic patients who cannot tolerate aspirin.

Surveys * made in 1966 and 1967 among private practice physicians showed an incidence of intolerance to aspirin ranging from 3-85%. The majority of physicians surveyed reported an intolerance in 10-30% of their patients.

How does this compare with your experience?

*by two independent national research organizations

WARREN-TEED PHARMACEUTICALS INCORPORATED
COLUMBUS, OHIO 43215
SUBSIDIARY OF **ROHM AND HAAS COMPANY**

10-30

Don't use Magan on all your patients–

consider Magan for those patients who cannot take aspirin because of gastric discomfort

Private Practice Physicians tried Magan on almost 700 patients whom they judged intolerant to aspirin and other salicylates.

The majority of these patients could take Magan and obtain the benefit of salicylate therapy.

magan® **an alternate salicylate**

(magnesium salicylate, W-T)

May be tolerated by some persons intolerant to aspirin by reason of gastrointestinal irritation.

Magan is a new salicylate product from Warren-Teed.

A single chemical entity . . . no coating, no buffering, sodium free and non-acetylated.

Composition: Each orange colored tablet contains 5 grains (approx. 325 mg) of magnesium salicylate.

Dosage: 1 or 2 tablets every 4 hours with a full glass of water.

What Is the Blue Shield "Usual and Customary" Program?

(One of a series prepared by Blue Shield)

Q: What is the purpose of the Blue Shield "Usual and Customary" program?

A: The "Usual and Customary" Program is an attempt on the part of Blue Shield to pay the patient's bill for covered services in full, creating a better relationship between the doctor, the patients and Blue Shield in the area of medical economics.

Q: Where did this concept begin?

A: In 1962 the House of Delegates of the Indiana State Medical Association passed what was known as Resolution #26 which encouraged Blue Shield to market a plan which would have no schedule of dollar allowances, but would pay the "usual and customary" charges in the area where the services were rendered. In addition, it stated that, "County Societies or regional groups of counties shall establish review committees responsible for reviewing, when necessary, unusual services or charges in the light of 'the going rate' concept for that locality."

Q: What is the AMA's position on the County Medical Society Review Committee concept?

A: In 1968 the House of Delegates approved its Board of Trustees report which says, "It is proper for the physician to establish the fee which he charges to any patient for the professional service rendered, with recognition of the fact that a duly constituted local medical society committee of his peers may appropriately review and pass upon the equity and justice of his charge."

Q: What is meant by the "usual and customary" fee?

A: The AMA and the ISMA have had difficulty in trying to define the terms "usual and customary." In general, legal precedence would seem to agree with the 1965 House of Delegates which used the following terminology: "Usual—The 'usual' fee is that fee usually charged for a given service by an individual physician to his private patient. Customary—A fee is 'customary' when it is within the range of usual fees charged by physicians of a similar training and experience, for the same service within the same specific and limited geographical area."

Q: In actual fact, what percentage of the doctors' fees for covered services are being paid in full by Blue Shield under this program?

A: Our current "Test of Performance" figures show that 95.4% of all doctors' fees for covered services are being paid in full under this program.

Q: Does Blue Shield set the fees that a doctor can charge under this program?

A: No, Blue Shield seeks only to reflect the fees being charged by the majority of the doctors in the various communities. The physician is still free to charge whatever his conscience dictates that his services are worth.

Q: What if a physician chooses to charge above what other doctors are charging in the community?

A: The AMA and the ISMA have for some time encouraged doctors to discuss fees with their patients prior to performing their services. If such a discussion takes place, this then becomes a contract between the doctor and the patient, and Blue Shield is no longer obligated to meet a fee which is above what most other doctors are charging in the community.

Q: What if a doctor charges above the "usual and customary" rate in the community and does not discuss fees prior to performing his service?

A: An individual letter is initially sent to the physician seeking to determine whether any unusual circumstances in the case would permit Blue Shield to make an additional allowance. If no such unusual circumstances were present, the claim is then referred to the local County Society Review Committee for their adjudication.

Q: What if a doctor does not agree with the Blue Shield statistical determination of a "usual and customary" charge?

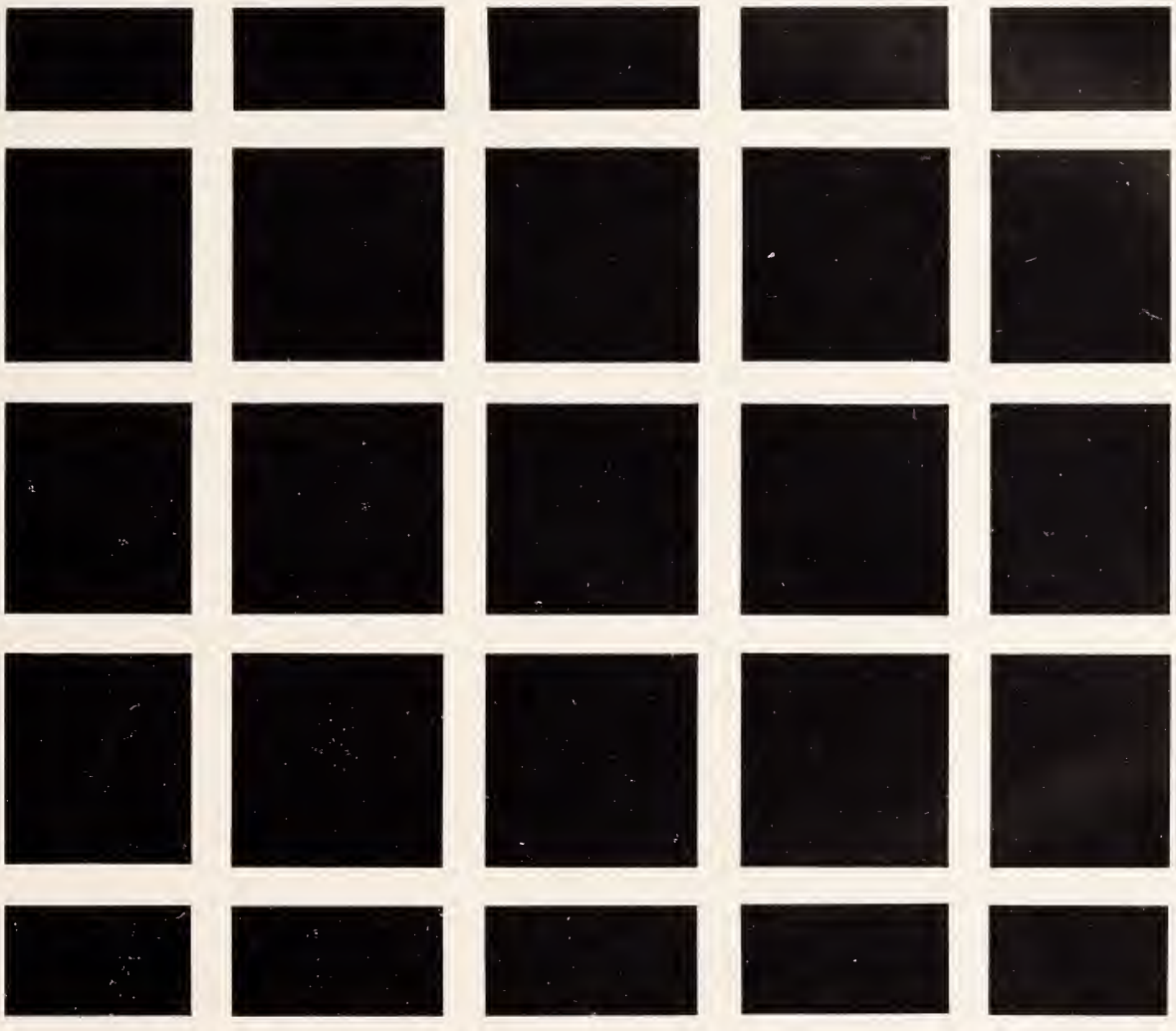
A: Any disagreement on the part of the physician with Blue Shield's statistical determination may be brought to the attention of the County Medical Society and a representative of Blue Shield will be available to appear, if requested, to attempt to resolve any difference in the statistical data.

Q: Is this program working in Indiana?

A: The success of this program is attested to by the fact that now more than 60% of our group business is written under this concept. With the ever-increasing pressure of the federal government to make "inroads" into the health care field, we believe that with the continued guidance and cooperation of the medical profession, we have found an answer that preserves the right of the physician to set his own fees while guaranteeing to the majority of the consumers that their medical bills for covered services will be paid in full. ◄

The error of our eye directs our mind.

William Shakespeare, *Troilus and Cressida (1601)*



Black squares on a white background. But you also see *gray spots* where the white lines intersect, don't you? Or do you—*really?* Now look at *just one* of the gray spots. Gone! Or was it ever there in the first place? So where does the error lie? In the mind . . . or the eye? In neither . . . or in both?

But it's no illusion that White-Haines directs its total resources toward clear vision . . . *errorless vision.* The diagnostic instruments which we offer you . . . the precision RX service . . . the supporting equipment and materials . . . are produced by people of the highest professional competence, through modern technologies which far transcend *ordinary* methods. We share your thinking on the importance of *errorless* visual services. Remember . . . White-Haines supplies *everything but the patient.*

THE WHITE-HAINES OPTICAL COMPANY
Headquarters: Columbus, Ohio
Serving Ohio • Michigan • Pennsylvania
West Virginia • Kentucky
Indiana • Illinois • Maryland

Medical Panorama

Generic Prescription Writing

A. W. CAVINS, M.D.
Terre Haute

THE great polemic goes on and on but there are still a few physicians who have a *logical* point-of-view which hews to the line, like a pioneer's broad-ax.

From a New England journal called *Massachusetts Physician* comes the following letter to the editor. From the sound of it, he might be a transplanted Hoosier—but see for yourself. Read his last paragraph, if nothing more.

To the Editor:

The debate over generic prescription writing has brought out some interesting arguments against interfering with the physician's right to practice medicine as he sees fit. The public is protected in part by the requirements of the Board of Registration in Medicine. Flagrant misuses of privilege to practice can be handled in a court of law, by the Committee on Ethics and Discipline of the Massachusetts Medical Society, and by the other curbs on improprieties.

If a physician is slack about prescription writing or his practice in general, the workings of the system of free enterprise soon take care of him. In other words, once the physician passes certain academic hurdles and the general requirements of respectability, he feels he can stay in practice without undue encroachment upon his liberties.

It seems to the M.D. that the only cogent reason for generic prescription writing is that it often leads to a smaller drug bill for the health and welfare agencies to pay. He is too cynical to believe the legislator would be so concerned over an individual's big drug bill. The M.D. sympathizes with the big health and welfare bill, but generic writing is not the answer to this problem and is only tangentially linked up with it.

Now, I can understand the binds on medical practice that make it necessary to report narcotic inventories. I understand the need for reporting births, deaths and certain diseases. These are related to the sound practice of medicine and the protection of the patient-public, but where does generic writing come in? It is linked to the cost of medical practice, not to quality. I cannot find any legal justification for the Commonwealth to be butting into the medical practice on a financial matter. Just where does the legislator get the right to tell me how to write a prescription if I have not jeopardized the health of the patient or the public?

NAME WITHHELD ON REQUEST ◄

221 S. Sixth St.
Terre Haute 47801

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation of and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available

Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.

Assistant Professor of Psychiatry and Medical Director

Area Code 704-253-2761

Dilantin®
(diphenylhydantoin)

PARKE-DAVIS

In untold thousands of epileptic patients... Dilantin has been, and continues to be, the bedrock of therapy.

DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anticonvulsant drugs.
PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. ADVERSE REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred.
DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.
Parke, Davis & Company, Detroit, Michigan 48232

The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium.

PARKE-DAVIS 015R67

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT — September, 1968

Disease	Sept. 1968	Aug. 1968	July 1968	Sept. 1967	Sept. 1966
Animal Bites	900	1177	1220	1134	931
Chickenpox	49	50	49	26	45
Conjunctivitis	97	94	103	43	62
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	19	50	7	32	54
Gonorrhea	555	640	521	583	501
Impetigo	247	211	108	139	214
Infectious Hepatitis	29	49	47	33	41
Infectious Mononucleosis	46	31	25	41	46
Influenza	701	191	78	226	280
Measles					
Rubeola	8	40	22	5	37
Rubella	36	58	27	9	37
Meningitis, Meningococcal	6	3	0	4	5
Meningitis, Other	2	5	2	6	9
Mumps	76	78	100	82	53
Pertussis (whooping cough)	21	28	15	50	17
Pneumonia	101	90	126	99	86
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	331	438	311	301	312
Syphilis					
Primary & Secondary	29	35	20	15	7
All Other Syphilis	121	145	58	101	101
Tinea Capitis	13	6	8	11	3
Tuberculosis (Active)	83	61	83	85	88

in the treatment of
IMPOTENCE

Android®
(thyroid-androgen) TABLETS

*Effectiveness confirmed by another double blind study**

1. SUMMARY
ANDROID — GOOD TO EXCELLENT 75%
PLACEBO — 20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

*"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths

Android
Each yellow tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY
Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY
Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C
Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

Write for literature and samples:
BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

REFER TO PDR

also available with ESTROGEN
Android-E
Each Tablet Contains:
Methyl Testosterone ..... 2.5 mg.
Ethinyl Estradiol ..... 0.02 mg.
Thyroid Ext. (1/6 gr.) ..... 10 mg.
Thiamine Hydrochloride ..... 10 mg.
Glutamic Acid ..... 50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE:** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS:** In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRA-INDICATIONS:** See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

ABSTRACTS, BOOK REVIEWS

CELL DIFFERENTIATION

Ciba Foundation Symposium, edited by A. V. S. DeReuck and Julie Knight, Little, Brown & Co., Boston, Mass., 1967; 267 pages with numerous illustrations; $12.00.

Cell differentiation continues being one of our most basic, still unsolved biological mysteries. The two dozen assembled experts talked at length and yet were candid in saying that the answers were not yet here.

What is the chemistry of the auxin and gibberellin in their specific effects? Just what makes a normal cell de-differentiate and become malignant? Just how do tumor and embryo tissue differ: basically?

The answers remain postponed—as yet. The clinician will not derive much benefit from the laborious lucubrations of the interim research workers, no matter how impressive their credentials.

As usual, the binding, type and paper are of top quality. Medical school libraries and the specialists in the field will want to acquire copies.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

INFECTIOUS DISEASES OF CHILDREN

Krugman, S., Ward, R., 4th edition. St. Louis, The C. V. Mosby Company, 1968.

The dramatic decrease of infectious diseases in children during the past three decades augments the need for definitive information on these ailments. Seeing most conditions but rarely, the practicing doctor urgently needs a readable text that will lead him swiftly and certainly to correct diagnosis and optimum treatment. The fourth edition of *Infectious Diseases of Children* by Professors Krugman and Ward fills this need admirably. It presents in an orderly manner most infectious diseases seen in developed countries, except the following with which the authors are not intimately familiar: tuberculosis, syphilis, malaria, yellow fever, leptospirosis and various mycotic infections.

All aspects of the common infectious diseases receive complete coverage, with special emphasis on treatment. The excellent illustrations include x-rays, photomicrographs and color plates. Perhaps most helpful of all are the schematic drawings illustrating the distribution of typical rashes in exanthemata, and the schematic diagrams showing graphically the chronologic sequence of such symptoms as fever, rash, lymph node enlargement and malaise for each ailment.

References are adequate and the text is uncluttered with bibliographic numbers. The writing is clear and the type is easily readable. In some case histories temperatures appear in centigrade, some in Fahrenheit, some in both. Centigrade always followed by Fahrenheit—at this point in time—would be preferable.

I would recommend this book for the office bookshelf of every pediatrician, family doctor and others who see children. Not only is it an enormously rich reference work, but also it offers a readable review of the newer knowledge of pediatric infections.

W. D. SNIVELY, JR., M.D.
Evansville

CARE OF THE GERIATRIC PATIENT

Edited by E. V. Cowdry, M.D., third edition, St. Louis, Mo., C. V. Mosby Co., 1968; 406 pp. with illustrations; $15.75.

The two previous editions of this work were considered classics in this field. In this edition, several chapters have been added. Modern medicine and public health measures have been preserving the lives of the young, resulting in a greater proportion of older citizens. Their care presents many problems for all physicians who treat older patients, mainly because their number has increased.

Doctor Cowdry has edited this volume from contributions of 38 eminent authorities of various disciplines of medicine. Especially outstanding is the chapter on cardiovascular aspects of aging by Paul Dudley White. He emphasizes prevention by the avoidance of over-nutrition and maintaining physical and mental activity throughout life. He is quite optimistic concerning rehabilitation of patients with cardiac disease. An interesting chapter on exercise is included. Here there is much information which is not found in the usual textbook.

There is also an informative chapter on living arrangements for the elderly, which may be a problem. Other chapters discuss the spiritual and sexual aspects of aging. The chapter on geriatric nursing is very informative for nurses involved in the care of the elderly.

The nurse not only is obliged to give personal care but must teach others to care for, support and encourage the elderly pa-

Continued

Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®: Glyceryl guaiacolate, 50 mg.; Dextromethorphan hydrobromide, 7.5 mg.
A. H. Robins Company, Richmond, Virginia 23220
A·H·ROBINS

tients. The idea is stressed that older people are individuals with individual characteristics. There is no prototype to follow.

Each chapter is supported by ample references. This book will be a valuable aid to all physicians and nurses who care for older individuals. The type is legible and the volume is sturdily bound.

DAVID A. BICKEL, M.D.
South Bend

TEXTBOOK OF ENDOCRINOLOGY

Edited by R. H. Williams, fourth edition, W. B. Saunders & Co., Philadelphia, 1968; 1258 pages with numerous illustrations; $24.00.

This latest, the fourth, edition of the leading monograph in its particular field continues to uphold the standards of excellence it established when it first came out after World War II. Of the score and more contributors, the output has been astonishingly good; the editor has managed to weld the whole into an harmonious whole with almost no duplication of material.

This textbook is aimed at the entire spectrum of the medical profession. The lowliest medical student will find it understandable; the most erudite professor of medicine will find material he might have overlooked. Every medical library will want this on its shelves. Almost all practicing physicians would be well advised to have the volume as a part of their well-thumbed working shelf!

As usual, the binding and printing are excellent. Typographical errors are few and far between. The paper will stand a lot of wear. The quoted price is well within reason for what the buyer is getting. Congratulations all around!

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

Abstracts From Various Literature, Prepared by AMA

BLIND ESOPHAGEAL COIN REMOVAL USING A FOLEY CATHETER

L. Brown, Jr. (Orthopedic Department, 125 DeSoto St., Pittsburgh)

Arch. Surg. 96:931-932, (June), 1968.

A new procedure for the removal of ingested blunt objects such as coins, jacks, and buttons which are lodged in the esophagus is described. By passing a Foley catheter through the nose and down the esophagus distal to the object, then inflating the Foley balloon and withdrawing the balloon and the object to the pharynx, the awake patient can expectorate the object and the Foley is then deflated and removed through the nose. The procedure avoids esophagoscopy and general anesthesia.

VENTRICULAR ANEURYSM AFTER MYOCARDIAL INFARCTION

G. Heberer et al. (Universitatsklinik, Cologne, West Germany)
Deutsch Med. Wschr. 93:975-984, (May 17), 1968.

Eight patients with postinfarction ventricular aneurysm are

ACHROMYCIN® V
TETRACYCLINE

Contraindications: Hypersensitivity to tetracycline.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Side Effects: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

LEDERLE LABORATORIES
A Division of
American Cyanamid Company
Pearl River, New York 10965

359-8

Suspected tetracycline-sensitive infection?

While waiting for the results of the sensitivity test, start the therapy likely to succeed...

Although of course it can't replace routine sensitivity testing, your prescription for ACHROMYCIN® V, in a way, provides the ultimate test of therapy under rigorous *in vivo* conditions.

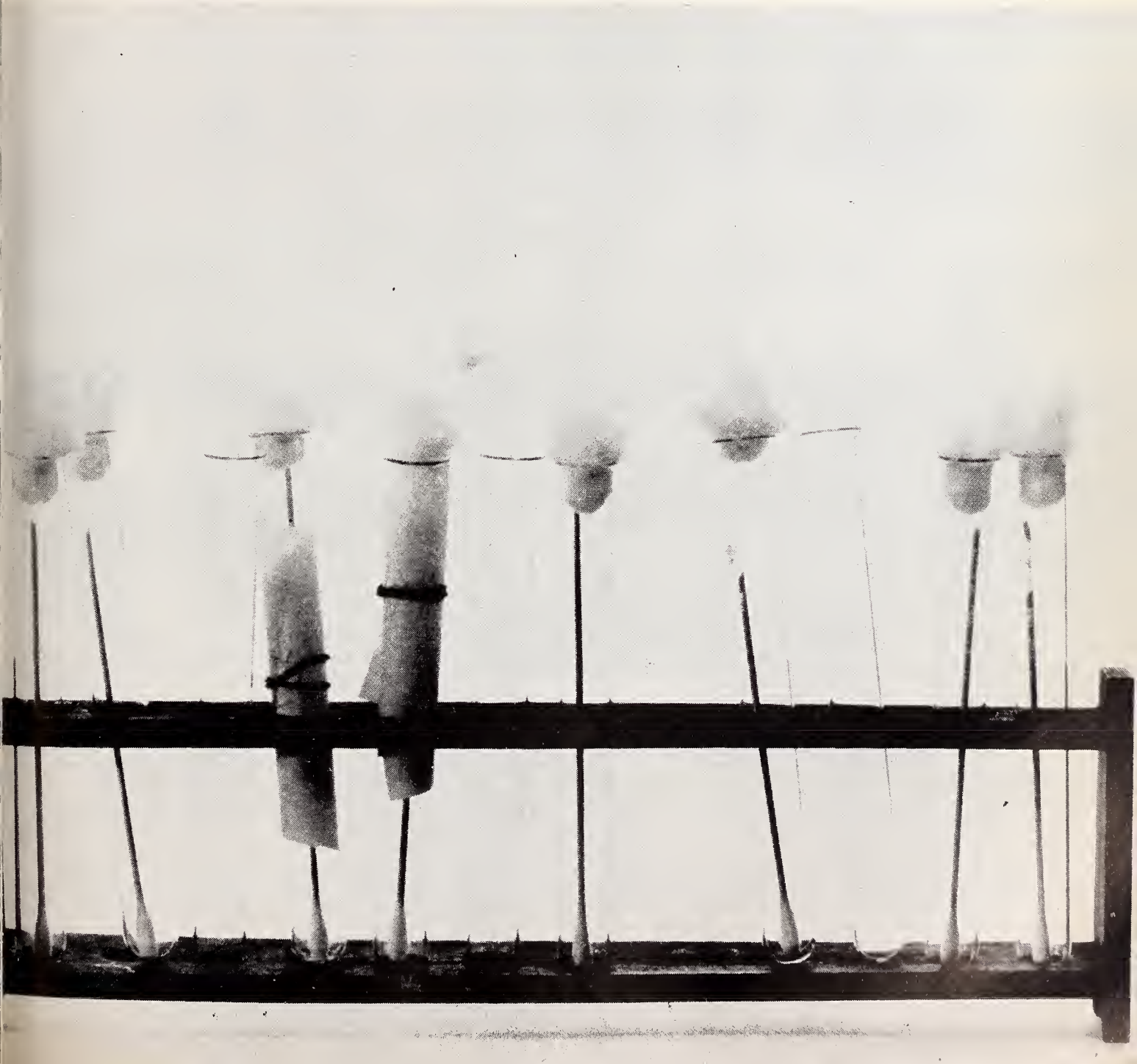
Because ACHROMYCIN® V is effective in treating so many common infections—caused by strains of tetracycline-sensitive organisms—doesn't *stat* dosage of this time-tested antibiotic make good sense?

←Prescribing Information

ACHROMYCIN® V
TETRACYCLINE

Lederle

The price differential is inconsequential.



Continued

reported. Resection of an aneurysm under cardiopulmonary bypass was successfully performed in five. Four of the survivors have resumed, or are about to resume their former occupation; one remains an invalid due to persisting angina.

SALMONELLOSIS EPIDEMIC RELATED TO CATERER-DELICATESSEN-RESTAURANT

A. F. Kaufman et al. (Communicable Disease Center, Atlanta)

Amer. J. Public Health 58:764-771, (April), 1968.

A common-source epidemic primarily due to *Salmonella meleagridis* occurred in a metropolitan area during May and June, 1965. Sporadic cases related to one delicatessen occurred from May 10th until multiple simultaneous outbreaks occurred on June 5th and 6th. Investigators interviewed 431 people who had attended nine separate parties. *S meleagridis* was recovered from 63 individuals who had attended six of the parties and from food served at three of the parties. In response to publicity, 142 people reported having had similar illnesses after eating at the delicatessen between June 4th and 7th. Stool specimens from 19 of these were positive on culture for *S meleagridis*. The organism was also isolated from food submitted by six individuals. *S meleagridis* was recovered from food-processing equipment, many ready-to-eat foods, and 64 of 115 employees. Environmental contamination, employee carriers, and poor food-handling practices perpetuated the outbreak. Periodic surveys showed no recurrence of contamination, and no additional cases related to the establishment had been reported.

ESCORT YOURSELF . . .

to Home Lawn Mineral Springs for a few days health vacation —the mineral baths and excellent meals in an atmosphere of serenity will leave your cares behind.

HOME LAWN
MINERAL SPRINGS
Martinsville, Indiana

M. C. Pitkin, M.D.
Medical Director

J. W. Gibbs, M.D.
Medical Director
Associate

ASPIRIN INJURY TO THE GASTRIC MUCOSA

W. B. Thorsen et al. (J. F. Morrissey, 1300 University Ave., Madison, Wis.)

Arch. Intern. Med. 21:499-506, (June), 1968.

A controlled study of the acute effects on the gastric mucosa of acetylsalicylic acid in an alkaline and an acid environment was performed in healthy students. Gastric blood loss was determined by the Hemastix method and direct visual observations of the gastric mucosa were made with a gastrocamera. Hemorrhagic lesions of the gastric mucosa are common in university students when aspirin tablets are ingested in the presence of a low intragastric pH. There were no reactions when the intragastric pH was alkaline. Gastrocamera photographs are presented to demonstrate the types of reaction which occurred. Findings suggest that acetylsalicylic acid rather than its sodium salt is injurious to gastric mucosa.

LINCOMYCIN AND PENICILLIN G IN TREATMENT OF MILD AND MODERATELY SEVERE PNEUMOCOCCAL PNEUMONIA. A COMPARATIVE STUDY

R. Anderson, M. Bauman, and R. Austrian (Hospital of University of Pennsylvania, Philadelphia)

Amer. Rev. Resp. Dis. 97:914-918, (May), 1968.

Treatment of 43 patients with pneumococcal pneumonia (13 of whom had bacteremia) with lincomycin, 0.6 gm intramuscularly every 12 hours, gave results comparable to those achieved in a control group of 40 patients treated with penicillin G. All strains of pneumococcus were identified serologically. One fatality following treatment with lincomycin resulted from superinfection with *Klebsiella pneumoniae*. Because pneumococcus may give rise to mutants resistant to lincomycin, isolation of the causative organism and measurement of its sensitivity to lincomycin is an essential facet of treatment with this antibiotic. Knowledge of the mode of action of lincomycin and of macrolide antibiotics suggests that these two classes of drugs should not be administered simultaneously.

PHENYLKETONURIA: MENTAL DEVELOPMENT, BEHAVIOR, AND TERMINATION OF LOW PHENYLALANINE DIET

I. M. Hackney et al. (W. B. Hanley, Hospital for Sick Children, Toronto)

J. Pediat. 72:646-655, (May), 1968.

Forty-six children with phenylketonuria were followed at the Hospital for Sick Children, Toronto, for 7½ years. In cases diagnosed and treated before the age of two years the eventual level of intelligence was above mental deficiency. When the IQ was within normal limits there were invariably mental handicaps resulting in poorer school progress than anticipated. There was a high incidence of autistic behavior in the group. Fourteen children arbitrarily removed from diet were studied for periods of 18 to 48 months. The children made satisfactory progress when diet was terminated at age five to eight years.

SUBCLAVIAN VEIN CATHETERS AS SOURCE OF FUNGAL BLOOD INFECTION

K. Kropelin, G. Mossner, and W. Gebhardt (Universitats Klinik, Freiburg)

Deutsch Med. Wschr. 93:1096-1099, (May 31), 1968.

Prolonged intravenous infusions through a catheter introduced into the subclavian vein were performed in ten patients. Five

Continued

You can be there with NCME TV!

The first nationwide medical television service, NCME—The Network for Continuing Medical Education—brings you visually the important achievements of leading medical authorities. By means of closed-circuit television, this independent network provides your hospital or medical school with a complete videotape service that helps shorten the gap between new medical knowledge and its availability for clinical or teaching purposes.

NCME
The Network for Continuing Medical Education

NCME TV Offers These Practical Benefits:

☐ Every two weeks a new 60-minute videotape dealing with three separate medical subjects is sent to participating institutions.

☐ Content and format of NCME telecasts fulfill criteria for postgraduate medical education, permitting American Academy of General Practice course credits under specified conditions.

☐ To help your institution make effective use of closed-circuit television, NCME offers a wide range of services and utilization aids, including: Technical consultation in setting up a closed-circuit system; advance program information on the contents of each telecast; display units to help publicize programs; expense-paid seminars to improve utilization of medical television.

☐ NCME programs are brief and may be shown as often as desired; you can view the telecasts at times that are most convenient, without disrupting your normal schedule.

☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to NCME, 342 Madison Avenue New York, N.Y. 10017

developed pyrexia, presumably due to infection associated with the indwelling catheter. In four instances blastomycetes were isolated either from venous blood, the catheter, or both.

ELECTRIC SHOCK HAZARD IN HOSPITALS

J. A. Hopps (National Research Council of Canada, Ottawa)

Canad. Med. Assoc. J. 98:1002-1006, (May 25), 1968.

Diagnostic or treatment procedures which introduce probes to the region of the heart increase the danger of induced ventricular fibrillation. The hazard is accentuated by the simultaneous use of other electronic equipment in the operating theatre, catheterization room or intensive care unit. Some operating room precautions against gas explosion increase the electric shock hazard. The author reviews arguments for and against revision of safety codes of Canada and the United States.

BASAL CELL EPITHELIOMA AT SITE AND FOLLOWING SMALLPOX VACCINATION

A. S. Zelickson (University of Minnesota Medical School, Minneapolis)

Arch. Derm. 98:35-36, (July), 1968.

This report describes a patient who developed a basal cell epithelioma at the site of and directly after a vaccination against smallpox.

ECHOENCEPHALOGRAM AFTER ACUTE HEAD TRAUMA

H. Richter (Chirurgische Universitats-Klinik, Tubingen, West Germany)

Deutsch Med. Wschr. 93:1144-1146, (June 7), 1968.

Some 500 echoencephalograms recorded after acute head trauma at the University Department of Surgery in Freiburg were analyzed. The method proved to be of great diagnostic value. It almost always allowed a clear-cut distinction between contusion and intracranial hematoma (practically no false-positives; proportion of error in doubtful cases was not more than 10% to 20%). In many instances the method has replaced carotid angiography.

"DEATH" FROM LIGHTNING AND THE POSSIBILITY OF LIVING AGAIN

H. B. Taussig (Johns Hopkins Hospital, Baltimore)

Ann. Intern. Med. 68:1345-1353, (June), 1968.

A review of a number of persons who were struck by lightning and recovered is presented. Statistics indicated more persons recover after being struck than are killed. A person struck by lightning is instantaneously rendered unconscious. Heart action and respiration cease. Spontaneous recovery may occur if respiratory narcosis is not too long. The heart usually starts in sinus rhythm with marked bradycardia. Minor electrocardiographic changes are common; myocardial infarction is rare. When the patient first regains consciousness he may be mute and unable to move. Burns may be severe but heal remarkably easily. Transient headache and hypertension are common. Fractures of the limbs or skull may occur when the person is thrown to the ground. Most of the reports concern spontaneous recovery. In strikingly few

HARDING HOSPITAL, Inc.

(A Fully Accredited Private Psychiatric Hospital)

WORTHINGTON

OHIO

For the Diagnosis and Treatment of Psychiatric Disorders

and with

Limited Facilities for the Aging

GEORGE T. HARDING, M.D.
Medical Director

D. L. HANSON
Administrator

Phone: Columbus 614-885-5381

reports was any effort made to resuscitate the person who had been killed. Nevertheless, cardiopulmonary resuscitation and prolonged artificial respiration are important for a person who appears to have been killed by lightning. Furthermore, if recovery occurs, it is usually complete except for possible impairment or loss of sight or hearing. If a group of persons are struck by lightning, attention should first be directed to the dead, as those who show signs of life will in all probability recover even though burns or injuries may need treatment.

CONTROL OF DIABETIC DIARRHEA WITH ANTIBIOTIC THERAPY

P. A. Green, K. G. Berge, and R. G. Sprague (Mayo Clinic, Rochester, Minn.)

Diabetes 17:385-387, (June), 1968.

The ability of oral antibiotic treatment to control diabetic diarrhea was documented at the Mayo Clinic by a double-blind study involving a patient with this condition. When the patient was given amphotericin B, the diarrhea subsided promptly only to recur when a placebo was substituted. The erratic behavior of diabetic diarrhea is indicated, however, by the fact that a remission eventually occurred and no further treatment was required. Although not all patients with diabetic diarrhea respond to antibiotic treatment, its trial merits consideration for those patients who are refractory to the simpler forms of treatment.

TISSUE COBALT CONTENT IN "BEER DRINKERS' MYOCARDIOPATHY"

J. Sullivan, M. Parker, and S. B. Carson (Creighton University School of Medicine, Omaha)

J. Lab. Clin. Med. 70:893-896, (June), 1968.

Tissue concentrations of cobalt, zinc, magnesium and manganese were determined in the hearts of patients dying from a clinically diagnosed alcoholic myocardiopathy associated with the consumption of beer containing cobaltous salts. In cardiac muscle of myocardiopathy patients, cobalt concentrations were elevated ten times the normal. Manganese, zinc and magnesium were decreased. The relationship of these changes to myocardial failure remains uncertain.

PARTICLES ASSOCIATED WITH AUSTRALIA ANTIGEN IN SERA OF PATIENTS WITH LEUKEMIA, DOWN'S SYNDROME, AND HEPATITIS

M. E. Bayer, B. S. Blumberg, and B. Werner (Institute for Cancer Research, Philadelphia)

Nature 218:1057-1059, (June 15), 1968.

Australian antigen is extremely rare in normal people in the United States. It is, however, common in patients with viral hepatitis (20%) in whom its presence seems to be transient. It is also common in patients with Down's syndrome and chronic anicteric hepatitis, and is found in high frequency in some forms of leukemia and in lepromatous leprosy. The antigen is persistent in some individuals, i.e., mongolism and lepromatous leprosy patients. These individuals probably have an impairment of their immune mechanism which may be inherited. There have been no consistent isolations of the virus which is thought to be the cause of virus hepatitis. From the present findings, Australia antigen found in patients with leukemia, Down's syndrome, and hepatitis seem to be associated with a particle. The biological nature of these particles is unknown; antigenic sites are thought to be present on the particles. ◄

One by one the family's downed Because the G.I. bug's around

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric*
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin,
and protects intestinal mucosa

Whether it's a 24-hour "bug", a food problem, or simply nervousness and anxiety, Parepectolin will bring the diarrhea under control until etiology can be determined. In some cases, Parepectolin may be all the therapy necessary.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) ..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified) .... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.
Usual Children's Dose: One or two teaspoonfuls three times daily.

RORER

WILLIAM H. RORER, INC.
Fort Washington, Pa.

Nothing else I've tried seems to work, so I decided to give you a crack at it.

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® tablets in two different formulations.

And let you control the dosage.

With Novahistine LP tablets and Novahistine Singlet tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

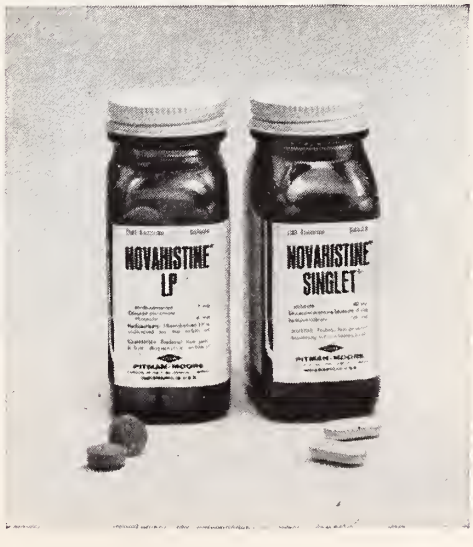
Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

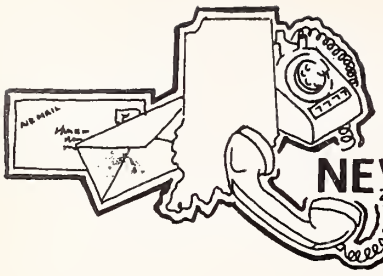
Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.

Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.



DOW PITMAN-MOORE DIVISION OF THE DOW CHEMICAL COMPANY, INDIANAPOLIS



NEWS NOTES

Directors of Medical Education Elect Dr. Donald Olson President

Dr. Donald T. Olson, Director of Medical Education in Memorial Hospital, South Bend, has been elected president of the Directors of Medical Education, State of Indiana.

Franklin A. Bryan, M.D., Coordinator of Medical Education in the Fort Wayne Medical Education Program, was elected vice-president and secretary. Outgoing officers of this association were President Jack Hall, M.D., Director of Medical Education in the Methodist Hospital, Indianapolis, Indiana, and vice-president and secretary Hyman Cohen, M.D., Director of Medical Education in Gary Methodist Hospital.

This Association is working closely with the Indiana Plan of medical education and is currently quite active in helping to retain and attract physicians to the state of Indiana through medical education. The purpose of this organization in addition to the above is to promote liaison between director's of medical education throughout the state. The membership may include institutions engaged in graduate and continuing medical education. Institutions which are not represented in this organization are encouraged to appoint a candidate for consideration for membership.

ARTIFICIAL LIMB WEARERS

Hanger Limbs are being successfully worn by amputees of oll oges. Dovid Canfield, just 13 months *(illustroted)*, is one of the mony young children graw-ing up on Hanger Legs. In contrast, Coptain W. T. Traylor, over 75 *(illustrated)*, naw wears his fifth Honger. He is a fire inspector who must cover continually haspitals, schoals, sports events, etc., and be on his feet for hours ot a time.

Age: 13 Months

The success of Hanger Limbs with omputees of such widely vorying types con be lorgely ottribut-ed to custom monufocture and individual fitting. Unusuol canditions are carefully in-vestigoted by experienced fitters, and limbs are manufoctured to meet individuol requirements.

Age: 78 Years

Hanger's experience af over 100 yeors is given ta every amputee sa that his rehabilitotion moy be successful.

Hanger PROSTHESES

1332 N. Illinois St., Indianapolis, Ind. 46202
3108 Burnet Avenue, Cincinnati, Ohio 45229
446 W. Pontiac Street, Fort Wayne, Ind. 46807
416 N. Main Street, Evansville, Indiana 47711

Dr. Price Named New Manager

Dr. Francis W. Price, Indianapolis, has been appointed as manager of the industrial medicine department of Eli Lilly and Company Kentucky Avenue plant. Dr. Price was in private practice in Indianapolis until 1967 when he joined the Lilly staff as staff physician.

U.S. Surgical Corporation Announces Drop in Operating Losses

The U. S. Surgical Corporation, developers and marketers of surgical stapling instruments, announces that its operating losses are decreasing.

The instruments, which place up to 66 tiny stainless steel surgical stitches, have topped 1,600 in sales. More than 70,000 loading units have been sold.

Developing costs are high in such a venture. A deficit of 18 cents a share for the first half of 1967 was improved to a deficit of 6 cents for six months in this year.

Dr. Wong Appointed

Dr. Samuel Nien-Tsu Wong, Hammond, has been appointed a member of the Hammond Board of Health. Dr. Wong is a native of China and on the staffs of St. Margaret and Our Lady of Mercy Hospitals there.

Dr. Huckleberry Re-appointed

Dr. Irvin E. Huck'eberry, Salem, has been re-appointed to another four-year term on the Washington County Board of Health by the Washington County Commissioners.

New Officers of the John Shaw Billings History of Medicine Society

Dr. William M. Loehr is the newly elected president of the John Shaw Billings History of Medicine Society for 1968-69.

Other new officers include: **Dr. David Rosenbaum,** vice-president and **Dr. Roy J. Korn,** secretary-treasurer. The new Chairman of the Board of Directors is Dr. Maynard K. Hine, Dean, Indiana University School of Dentistry.

Dr. James E. House, Indiana University School of Dentistry, is the newly elected member of the Board of Directors. Other members of the Board are Dr. Warren Andrew, Mrs. Dorothy Russo and Mrs. S. D. Stabler.

Dr. Halleck Honored

Dr. Harold J. Halleck, Winamac physician, was recently honored for his forty years of service to the community by the Pulaski County Medical Society.

Dr. Moore Re-elected

Dr. Robert G. Moore, Vincennes, has been re-elected president of the board for another year at the Hillcrest Hospital.

Medical Publishing Firm May Become New "CBS Affiliate"

The W. B. Saunders Company, medical publishing firm, will be acquired by the Columbia Broadcasting System if approved by Saunders shareholders, and if approved by the Internal Revenue Service.

The purchase price will be in the vicinity of $60 million. Saunders will operate as a division of the CBS/Holt Group.

Dr. Sandock Attends Conference

Dr. Louis F. Sandock, South Bend, was a delegate from the Indiana Society of Internal Medicine to a recent regional meeting of the American Society of Internal Medicine in Phoenix, Arizona.

Dr. Snodgrass Gives Address

Dr. Robert E. Snodgrass, Indianapolis, recently addressed the District I.S.N.A. at the Indiana Masonic Home Hospital. His topic was "Psychiatric Nursing in the Small Community Hospital."

Frank Woolley Named

Frank K. Woolley, for the past several years the AMA Field Service Representative for Indiana and adjacent states, has been appointed the new Executive Director of the Association of American Physicians and Surgeons.

New Employee Educational Folder On Emergency Fire Fighting Issued

A new employee educational folder on emergency fire fighting in industrial and commercial operations has just been issued by the National Fire Protection Association. It would, apparently, apply also to hospitals.

It stresses the importance of everyone knowing how to operate all types of extinguishers and how to select the proper type. It also stresses the value of knowing all fire exit routes.

A sample copy may be obtained by writing the Association at 60 Batterymarch St., Boston 02110. Quantities are available at $2.00 per 100 or $17.50 per 1,000.

Dr. Herd Attends Seminar

Dr. Cloyn R. Herd, Peru, recently attended the Indiana Academy of General Practice Postgraduate Seminar in Marion.

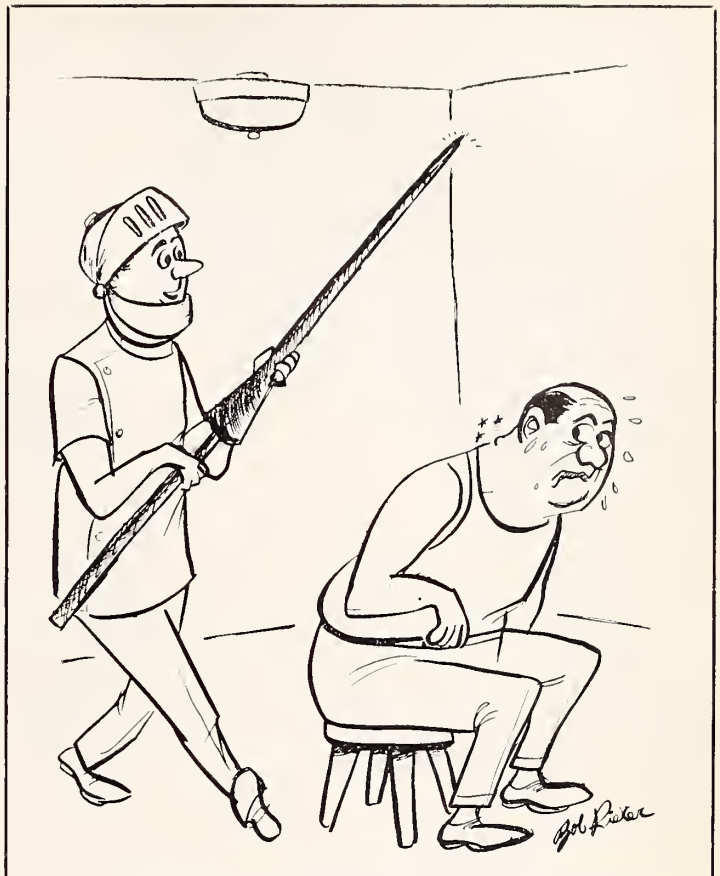
Dr. Province Attends Meeting

Dr. William D. Province, Franklin, recently attended a committee meeting in New York of the National Board of Tuberculosis Guidance Program.

Mr. Heine Appointed

Robert E. Heine, vice-president for pharmaceutical operations, Eli Lilly and Company, has been appointed as an alumni member of the Purdue University Board of Trustees to fill the unexpired term of the late Louis R. Lowe.

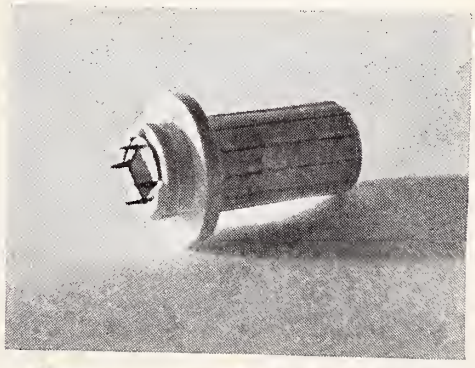
Continued



Now. Where is that boil you wanted lanced?

To fight TB- find it first!

Make tuberculin testing routine with every physical examination.



TUBERCULIN,TINE TEST (Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

Lederle

330—8/61.5

Dr. Frank Honored

Dr. John R. Frank, Valparaiso, who has practiced medicine there for the past 37 years, was awarded a 50-year Masonic award at a recent ceremony at the Masonic Temple.

Dr. Vietzke Honored

Dr. Paul C. F. Vietzke, Valparaiso, has been awarded a certificate and silver pin honoring him for 25 years membership and service with the Valparaiso Kiwanis club.

New Cancer Detection Film Now Available to Physicians

A new 20-minute color film entitled "Cancer Detection: Routine Proctosigmoidoscopy" has been produced by the C. B. Fleet Co.

Dr. Roald Grant of the American Cancer Society has praised the photography and teaching value of the film. It is available for showing to physicians by writing Fleet at P. O. Box 1100, Lynchburg, Virginia 24505.

Dr. Fulper Gets War Award

Dr. James C. Fulper, Terre Haute, recently was awarded the Bronze Star with "V" device attached. Responding to a call for extra medical assistance, Capt. Fulper jumped with his medical equipment nearly 14 feet to the ground from a hovering helicopter and quickly cared for 15 wounded men, preparing them for evacuation, disregarding heavy enemy ground fire. He has been in Vietnam since July and in the Army for nearly two years.

Dr. Pippenger Given Honor

Dr. Wayne C. Pippenger, Muncie, has been elected a Fellow of the National American College Health Association.

Johns Hopkins Physician Wins Passano Foundation Award

Dr. John Eager Howard, Professor of Medicine at The Johns Hopkins University School of Medicine, received the Passano Foundation Award at the recent AMA annual meeting. The award consists of $5,000 and is given annually to honor outstanding men of medical science.

The Williams & Wilkins Company, publisher of medical books and journals, sustains the award. A measure of the prestige of the recognition is that six previous recipients have subsequently received Nobel prizes. Dr. Howard is known for his work on blood calcium and excessive amounts of Vitamin D, and also for his original work on hypertension due to unilateral renal disease.

Dr. Alcorn Gives Address

Dr. Merritt O. Alcorn, Madison, recently spoke to 50 representatives of the Ninth District of the Indiana State Nurses Association during a meeting at King's Daughters Hospital.

Dr. Jay is Speaker

Dr. James M. Jay, Indianapolis, a specialist in internal medicine, recently returned from a tour of volunteer service in the Congo, under the "Operation Doctor" program, described his experiences for the School of Life at the New Richmond Methodist Church.

Veterans Administration Maintains Three "Out-of-Hospital" Facilities

The Veterans Administration maintains three types of medically oriented facilities, other than hospitals, for the interim care and rehabilitation of service-connected veterans' disabilities, and also other qualified veterans on the basis of need and if space is available.

Nursing homes admit only those who have attained maximum benefits at a VA hospital and who still require lengthy care. Some of these veterans may be unable to care for themselves. Domiciliaries and restoration centers are open to those who may not be able to live competently on the outside, but who can make decisions and care for themselves physically. Restoration centers emphasize rehabilitation. Four of the domiciliaries admit women veterans. Information on the entire program is available from any VA office.

Dr. Dorrance is Speaker

Dr. Thomas O. Dorrance, Bluffton, spoke before the Wells County Mental Health Association on "The Problems Confronting the Vera Cruz Opportunity School" at a recent meeting held in the Clinic Research Building.

Dr. McAtee Gives Address

Dr. Ott B. McAtee, superintendent at the Madison State

Continued

Doctor's House Call

Monday through Friday
7:25 A.M., 1:25 P.M. and 4:25 P.M.

Three times each day, Monday through Friday, Dr. James Rogers Fox discusses a variety of important medical questions. Using brief and simple explanations, Dr. Fox will answer many of the questions so important in our day-to-day living.

Sponsored by: **HOOK DRUG COMPANY**

WFBM tv 6 INDIANAPOLIS

Hospital, recently addressed the Rushville Unitarian Fellowship on "The Handling of Guilt and Anxiety."

Practical Nurses Maintain Continued Nursing Education

Licensed practical nurses, through their national professional organization, are providing for continued nursing education and upgrading of skills and knowledge.

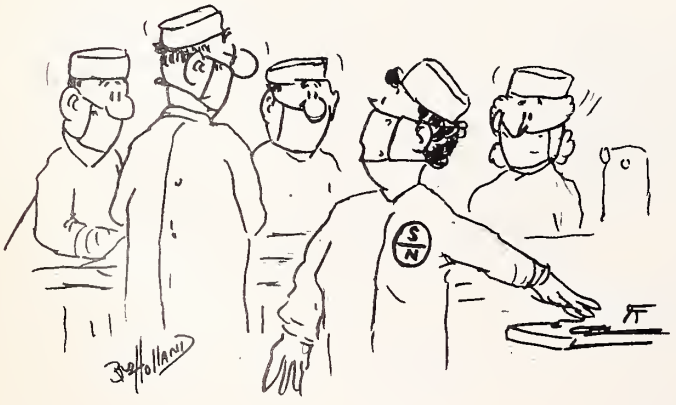
The National Federation of Licensed Practical Nurses (NFLPN) inaugurated a Postgraduate Assembly at its annual convention in Oklahoma City, September 30 through October 4. An entire day was devoted to "Diagnosis and Treatment of Diabetes."

Dr. Strickland Speaker

Dr. Neil R. Strickland, Indianapolis, recently presented two films and spoke on cancer detection at Lawrence Central High School.

Dr. Ellis Named

Dr. Davis W. Ellis, Rushville, was recently named a member of the Executive Committee of the newly created Butler University Dads' Association. The purpose of the association is to encourage active interest of Butler student's dads in the university's activities.



Don't have a No. 40 catheter, Dr. Reese.

How about two No. 20's?

Dr. Honan Re-elected

Dr. Paul R. Honan, Lebanon, has been re-elected president of the Boone County YMCA.

Dr. Wilson Named

Dr. John D. Wilson, Evansville, has been appointed to a one-year term on the committee on clinical investigation of the American Academy of General Practice.

PMA Faculty Development Awards Continued for 1969

The "Faculty Development Awards in Clinical Pharmacology" program of the Pharmaceutical Manufacturers Association Foundation will be continued in 1969. The awards are given to selected medical schools for use by specific staff members in clinical pharmacology.

The purpose is to relieve the acute manpower shortage in the field of drug investigation. Award winners are chosen by the PMA Foundation Directors with the advice of a nine-member committee of which Dr. Glenn W. Irwin Jr. of Indianapolis is a member.

Doctors on Panel

Drs. David J. Dietz and Herbert E. Ware, both of Muncie, and **Dr. Ross L. Egger, Daleville,** participated recently on a panel entitled, "How to Hang Your Shingle." The discussion was held before approximately 100 medical students from the Indiana University School of Medicine and their wives.

Dr. Marks Reappointed

The reappointment of **Dr. Howard H. Marks, Huntington,** to the Huntington County Board of Health was approved by the County Commissioners at a recent meeting. Dr. Marks will serve a three-year-term.

Dr. Kopcha is Speaker

Dr. Joseph E. Kopcha, Gary physician and former Chicago Bear football star, recently spoke for the "Family Day Observance" conducted by St. Mary's Byzantine Rite Catholic Church.

Pfizer Scholarship Winner

Henry J. Marchiniac, Jr. of Fort Wayne is the recipient of the Pfizer Laboratory $1,000 scholarship for the 1968-69 school year at Loyola University Medical School. Pfizer provides a similar scholarship at each of the 99 medical schools in the United States.

Dr. Elkins Named

Dr. James P. Elkins, Indianapolis, was installed president of Indianapolis Chapter No. 66 of the National Sojourners at a recent meeting at the Heslar Naval Armory.

Dr. Wojcik Presents Program

A talk on "Mental Retardation" was presented by **Dr. Ladislas D. Wojcik, Marion,** for members of the Marion Welcome Wagon Club.

1968 Arthritis Writing Competition Announced

The Arthritis Foundation announces opening of the competition for the 1968 Russell L. Cecil Writing Awards in arthritis.

Three awards (of $500, $200 and $100) are offered annually in

each of three media categories: newspaper, magazine and broadcast writing.

All entries in the current competition must have been published or broadcast in media available to the general public in the U.S. between January 1 and December 31, 1968.

Writers in these fields are invited to enter the 1968 contest. The Foundation calls special attention to the fact that 1967 awards in magazine writing and broadcast writing were withheld because the judges considered none of the entries up to Cecil prize standards.

Dr. Lamb Named

Dr. Russell W. Lamb, Indianapolis, was named "Shriner of the Year" during a recent award ceremony in the Murat Temple.

Dr. Fischer Appointed

Dr. A. Alan Fischer, Indianapolis, has been appointed to the publications committee of the American Academy of General Practice.

Four Drug Industry Associations Form New International Body

Four drug industry associations, those representing Canada, the Common Market countries, the European Free Trade Area and the United States, have formed an international body to assist in the production and distribution of drugs, especially in the underdeveloped countries.

The new group is named the International Federation of Pharmaceutical Associations. C. Joseph Stetler, president of the Pharmaceutical Manufacturers Association (USA) and William H. Conzen, president of the Schering Corporation are members of the seven-man council of the Federation.

Dr. Bowers Honored

Dr. C. Richard Bowers, Anderson, has been named the winner of the 1968 Toner Award, given annually to the Indiana resident who has made an outstanding contribution in either the area of improving international understanding and good will or who has performed an outstanding service for the United Nations or in encouraging support for the United Nations.

Dr. Hill Named

Dr. Theodore A. Hill, South Bend psychiatrist, has been appointed superintendent of Norman Beatty Memorial Hospital, the Indiana Department of Mental Health announced recently.

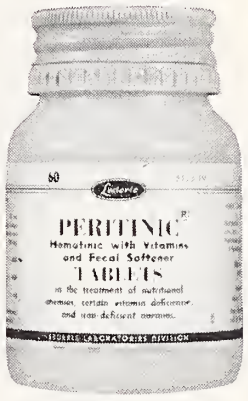
Dr. Turner Named

Dr. Anna Goss Turner, Madison, was named winner of the 1968 Community Service Award during a recent meeting of the Greater Madison Chamber of Commerce.

Dr. Adams Appointed

Dr. Max R. Adams, Flora, has been appointed Medical Officer at Naval Avionics Facility in Indianapolis. Dr. Adams' specific duties will be supervising the administration of medical treatment to approximately 3,400 civilian employees, 11 military officers and their families. ◄

anticostive* hematinic



PERITINIC®

Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

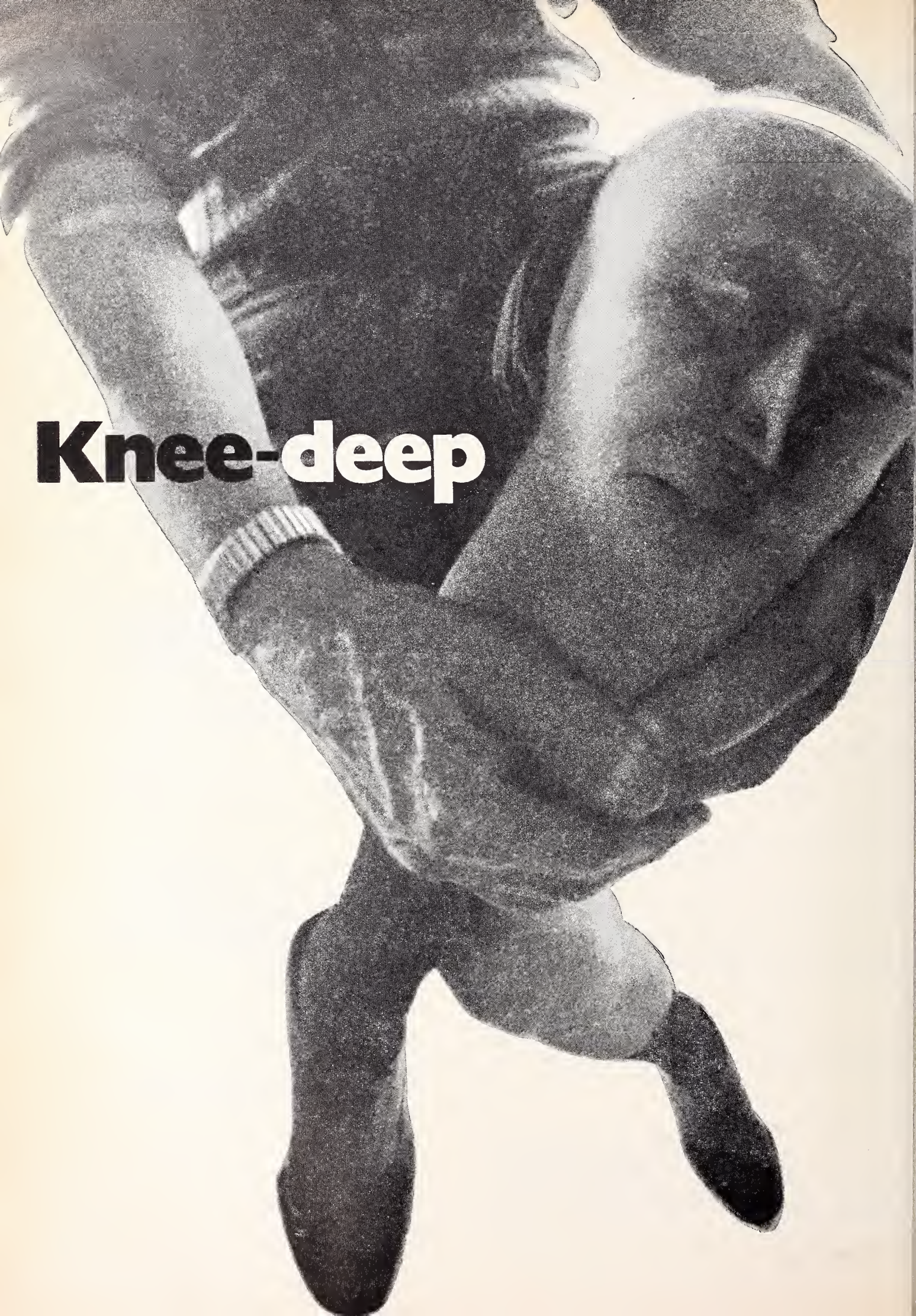
● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

* anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

488-7R—6062


Knee-deep

in osteoarthritic pain

If aspirin doesn't help, move in with Tandearil.

The trial period is brief: 1 week. Try one tablet q.i.d. at first. Tandearil usually starts working within 3 to 4 days. When response occurs, as little as 1 or 2 tablets daily may hold back pain and stiffness, and increase joint motion.

On the next page is a summary of adverse reactions, contraindications, warning and precautions.

Tandearil.
It can help get his mind off his knee.

Please review full Prescribing Information carefully before prescribing.

For osteoarthritic knees, spines, shoulders, hips, etc.:

Tandearil®
oxyphenbutazone

Tandearil, oxyphenbutazone:
For brief summary see next page.

Geigy

TA-6006

Tandearil®
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

(B)R-46-800-A

For complete details, please see full Prescribing Information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION ANNUAL CONVENTION
Date Dec. 1-4, 1968
Place Miami Beach, Fla.

NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville

INDIANA PSYCHIATRIC SOCIETY
Date Second Wednesday of the month October through May, excluding December
Place The Athenaeum, Indianapolis

AMERICAN COLLEGE OF SURGEONS INDIANA CHAPTER
Date April 17-19, 1969
Place Purdue University, West Lafayette

INDIANA ACADEMY OF GENERAL PRACTICE
Date April 15-17, 1969
Place Evansville

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
Date April 30-May 1, 1969
Place Imperial House, Columbus

INDIANA ASSOCIATION OF PATHOLOGISTS, INC.
Date December 7, 1968
Place Indianapolis Motor Speedway Motel

INDIANA CHAPTER OF AMERICAN ACADEMY OF PEDIATRICS
Date May 14-15, 1969
Place Stouffer Inn, Indianapolis

INDIANA DENTAL ASSOCIATION
Date May 10-14, 1969
Place Murat Temple and Essex House Motel, Indianapolis

INDIANA PUBLIC HEALTH ASSOCIATION, INC.
Date April 22-24, 1969
Place Stouffer Inn, Indianapolis

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 13-16, 1969
Place Indianapolis

INDIANA ROENTGEN SOCIETY
Date May 4, 1969
Place Holiday Inn, Indianapolis

INDIANA SOCIETY OF ANESTHESIOLOGISTS
Date May 24, 1969
Place Marott Hotel, Indianapolis

INDIANA STATE LICENSED PRACTICAL NURSES' ASSOCIATION, INC.
Date May 5-9, 1969
Place Robert Lee Motel, New Albany

INDIANA STATE NURSES ASSOCIATION
Date October 16-18, 1969
Place Civic Auditorium, Evansville

INDIANA MEDICAL BUREAU
816 Hume Mansur Bldg.
631-5802

A Licensed Employment Agency
Specializing in Medical Personnel

Our 18th Year Of Service

County, District News

Tenth District

The Tenth District Medical Society met Sept. 25 for its annual fall meeting and elected the following new officers: Drs. R. J. Doherty, Crown Point, president; Lambro Dimitroff, Calumet City, Ill., secretary-treasurer; V. J. Santare, Munster, councilor and Charles T. Disney, Gary, alternate councilor.

Eleventh District

Dr. J. D. Pattison, Marion, was elected president of the Eleventh District Medical Society Sept. 18 when the group met at Delphi. Other new officers include: Drs. Fred Poehler, La Fountaine, secretary-treasurer; James A. Harshman, Kokomo, alternate councilor and Marcene Pearcy, Marion, Blue Shield Board member.

Thirteenth District

New officers of the Thirteenth District Medical Society are: Drs. John Kerrigan, Michigan City, president; James D. Finfrock, Elkhart, president-elect; John O. Hildebrand, South Bend, secretary-treasurer and Otis R. Bowen, Bremen, councilor.

Allen

The Allen County (Fort Wayne) Medical Society met Sept. 3 to hear Dr. Hurst B. Hatch, Jr., Associate Professor of Medicine at Tulane University, speak. His topic was "Inhalation and Perfusion Lung Scanning in the Assessment of Pulmonary Function."

Cass

Dr. H. B. Matheu, superintendent of Longcliff State Hospital, spoke on the Unit Care System recently implemented at Longcliff at the Sept. 9 meeting of the Cass County Medical Society. Forty members and guests attended the meeting.

Clark

Field Secretary Robert Amick met with the Clark County Medical Society Sept. 17 to report on the annual convention and other matters of interest.

Clinton

Field Secretary Howard Grindstaff met with the Clinton County Medical Society Sept. 24 to discuss matters of interest to the members.

Dearborn-Ohio

Dr. A. K. Rhodes, Lawrenceburg, spoke on the "Rh Factor" at the Sept. 5 meeting of the Dearborn-Ohio County Medical Society.

Fayette-Franklin

The Fayette-Franklin County Medical Society met Sept. 10 at the Hearthstone Restaurant near Metamora. Ortho Laboratories presented a program on Rho-Gam, the new breakthrough drug used in handling the Rh negative mother.

Floyd

New officers of the Floyd County Medical Society are: Drs. William F. Ruoff, president; Donald R. LaFollette, vice-president; and Daniel H. Cannon, secretary-treasurer.

Huntington

Dr. J. B. Bennett, Warren, showed slides and talked on his two months voluntary service in Vietnam at the Sept. 10 meeting of the Huntington County Medical Society. New officers taking office in September were: Drs. Wayne S. Miller, president; Howard Marks, vice-president and Stanton E. Cope, secretary-treasurer.

Marion

New officers of the Marion County Medical Society were installed in ceremonies at Indianapolis in September. The new officers are: Drs. Hugh K. Thatcher, president; Donald E. Stephens, vice-president; A. Alan Fischer, secretary-treasurer and John O. Butler, president-elect.

Owen-Monroe

John Pont, Indiana University football coach, spoke at the Sept. 26 meeting of the Owen-Monroe County Medical Society. Fifty members and guests attended.

Shelby

Dr. Harry Siderys, Indianapolis, spoke at the Sept. 5 meeting of the Shelby County Medical Society on the current medical and surgical management of pulmonary neoplasms. Seventeen members attended.

Sullivan

Dr. M. H. Bedwell, Sullivan, has been elected president of the Sullivan County Medical Society. Other officers are: Drs. K. W. Eskew, Sullivan, vice-president and J. S. Brown, Carlisle, secretary-treasurer.

Tippecanoe

James Imboden, Columbus, Ind., spoke on "Political Action" at the Sept. 10 meeting of the Tippecanoe County Medical Society. Imboden is a representative of AMPAC.

Vanderburgh

A demonstration panel from "Recovery, Inc." presented the program at the Sept. 10 meeting of the Vanderburgh County Medical Society. Recovery, Inc., is a non-profit organization which offers self-help after-care to prevent chronicity in nervous patients and relapses in former mental patients. The demonstration was presented by six members from the two Recovery groups in Evansville.

Wayne-Union

The Sept. 12 meeting of the Wayne-Union County Medical Society was highlighted by a dinner with the Wayne and Union County Bar Associations. Speakers were David Dennis (Rep.) and William Norton (Dem.), candidates for the Tenth Congressional District. A discussion on political issues ensued, with questions directed to both candidates from a panel and from the floor. ◄

FUTURE MEETINGS, SEMINARS, COURSES

University of Colorado Offers General Practice Review Course

The fifteenth annual postgraduate course on "General Practice Review" will be conducted January 12-18, 1969, at the University of Colorado School of Medicine at Denver.

Courses offered during the week-long course will include: Crisis Recognition and Treatment; Medicine; Pediatrics; Dermatology; Surgery; Obstetrics and Gynecology and Trauma. For further information and detailed program, write: The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. Ninth Ave., Denver 80220.

Tulane University Fourth Annual Postgraduate Cruise Course

"Fractures and Other Injuries" will be the subject of the Tulane University School of Medicine Fourth Annual Postgraduate Cruise Course.

The cruise will be on the MS Europa from March 14 to 27, 1969, with stops at seven ports and seven days devoted to medical lectures. A distinguished faculty will conduct the instruction. Dr. Jack K. Wickstrom of Tulane is the director and Dr. Sam W. Banks of Chicago is the Cruise Consultant.

For complete information write Allen Travel Service, 565 Fifth Ave., New York City 10017.

The University of Chicago Offers Postgraduate Courses

Postgraduate courses on "Malabsorption Problems" and "Thyroid Disease" are being offered by the University of Chicago Hospitals and Clinics. The course on "Malabsorption Problems" will be offered December 11, 1968 and the one on "Thyroid Disease" will be January 8, 1969.

If you would like additional information, write: Frontiers of Medicine, The University of Chicago, 950 E. 59th St., Chicago 60637.

Eighth International Congress Of Gerontology Set for 1969

The Eighth International Congress of Gerontology will be held on August 24 to 29, 1969 in the Sheraton Park and Shoreham Hotels, Washington, D. C.

For details of the program, registration fees and membership in the Congress address the Secretariat, 8th International Congress of Gerontology, 9650 Rockville Pike, Bethesda, Maryland 20014.

22nd National Conference on Rural Health Will be March 21-22

The 22nd National Conference on Rural Health will be held at the Philadelphia Marriott Motor Hotel, in Philadelphia on March 21 and 22, 1969. The theme of the conference will be "Meeting Rural Health Needs In Our Changing Times."

The purposes are: (1) To develop effective planning methods for community health services; (2) To discuss effective ways for delivery of health services in rural areas; (3) To review methods for efficient utilization of health resources, and (4) to study community organization for meeting health needs. For full particulars write the Council on Rural Health, 535 N. Dearborn, Chicago 60610.

University of Colorado Offers Postgraduate Course on "Crisis Recognition"

The University of Colorado will conduct a postgraduate course on "Crisis Recognition and Treatment" on January 12, 1969.

The program will be presented by both the Colorado faculty and guest speakers. Registration and tuition fees and further information on the course may be obtained by writing Postgraduate Medical Education, 4200 E. Ninth Ave., Denver 80220.

Postgraduate Course in Medical Technology May 12-16

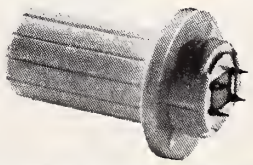
A postgraduate course in Medical Technology will be conducted by the University of Colorado School of Medicine at the YMCA Conference Center in Estes Park, Colorado, next May 12 to 16.

It is designed primarily for the medical technologist. The tuition and registration fees for the five days are $75.00. For more information write Postgraduate Medical Education, 4200 E. Ninth Ave., Denver 80220.

Sectional Meeting of the American College of Surgeons

Members of ISMA are invited to attend a Sectional Meeting of the American College of Surgeons to be held at Louisville on

Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?
or
HISTO?
(Histoplasmosis—"The Masquerader")

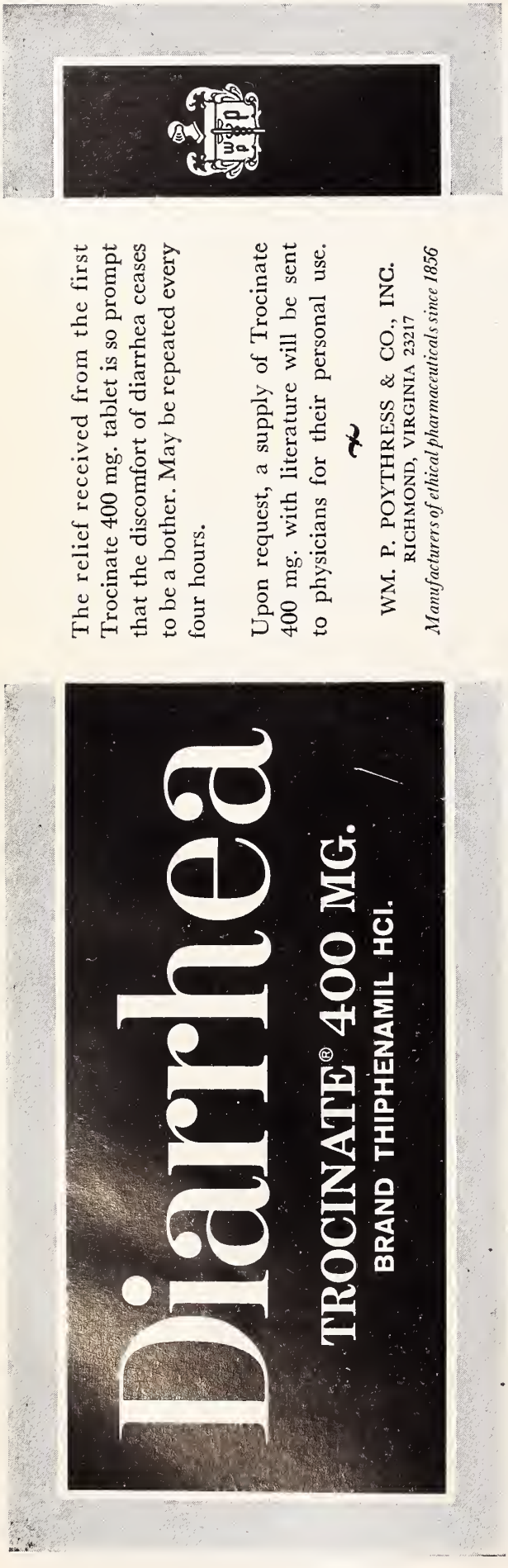


A new aid in differential diagnosis
HISTOPLASMIN, TINE TEST
(Rosenthal)
The LEDERTINE™ Applicator with the Blue Handle

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle

Ask your representative for details or write Medical Advisory Dept., Lederle Laboratories, Pearl River, New York 10965. 406-8



Continued

February 24 to 26, 1969, at the Brown Hotel.

A symposium on trauma will highlight the meeting, with general and specialty coverage. The Ob-Gyn and the neuro surgical programs will be outstanding. A fee of $15.00 is charged to physicians not members of the College. Residents are admitted free upon presentation of a letter of identification from their service chief.

Postgraduate Seminar in Surgery Will be Presented January 15-18, 1969

The University of Miami School of Medicine will present a Postgraduate Seminar in Surgery at the Eden Roc Hotel in Miami Beach on January 15 to 18, 1969.

The subject will be "Art and Science in the Therapy of Difficult Problems in Surgery." A distinguished panel of guest professors will assist the Miami faculty. Write the Jackson Memorial Hospital, P.O. Box 875, Biscayne Annex, Miami, Florida 33152 for further information.

Society of Cryosurgery Sets January 12-17, 1969 Meeting

The Society of Cryosurgery will hold its annual meeting at the Hilton Plaza at Miami Beach on January 12 to 17, 1969.

The application of cryosurgery in the specialties of ophthalmology, neurosurgery, otolaryngology, urology, gynecology, dermatology and oncology will be considered. All physicians and surgeons are invited to attend.

Write to Dr. John G. Bellows, 30 N. Michigan Ave., Chicago 60602 for further details.

Tenth Medical Seminar Cruise Reservations Now Being Accepted

The Department of Postgraduate Medicine of Albany Medical College announces that reservations are now being accepted for the Tenth Medical Seminar Cruise, January 6-23, 1969.

The 17-day cruise from New York will be aboard the luxurious and distinguished ship "Gripsholm" of the Swedish American Line. Ports of call include St. Croix, Martinique, St. Vincent, Barbados, Grenada, Trinidad, LaGuaira, Venezuela, Curacao and Jamaica.

Faculty of Albany Medical College will present a comprehensive shipboard postgraduate program, covering subjects in medicine, surgery, pediatrics, obstetrics and gynecology.

Request has been made for continuation study credit for the members of American Academy of General Practice.

Postgraduate Courses Listed By Cleveland Clinic Foundation

Six postgraduate courses are listed by the Cleveland Clinic Educational Foundation for the month of January, 1969.

The first, "Advances in Neurology," will be offered January 8 and 9; the second, "Surgical Problems of the Liver, Biliary System, Pancreas and Spleen" will be given on January 15 and 16 and "Cardiovascular and Renal Clinical Pharmacology" on January 20 and 21.

Write the Education Secretary, Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland 44106 for further information. ◄

Relax...

Let us worry about
your delinquent accounts

Collecting past due accounts takes time, effort and worry. If you're working more lately and enjoying it less because of delinquent accounts, it's time to call in a specialist. Our experienced staff members are experts in collecting past due accounts while preserving the vital doctor-patient relationship.

Enjoy yourself! Call us today and we'll do the worrying!

Associated Credit Bureaus

OF INDIANA

affiliated with

ASSOCIATED CREDIT BUREAUS OF AMERICA

Contact your local ASSOCIATED CREDIT BUREAU OF INDIANA *member*

Association News

EXECUTIVE COMMITTEE

September 19, 1968

Meeting called to order at 12:00 Noon by the chairman, Dr. Ralph V. Everly.

Present: Ralph V. Everly, M.D., chairman; Burton E. Kintner, M.D., G. O. Larson, M.D., P. J. V. Corcoran, M.D., Lowell H. Steen, M.D., Lester H. Hoyt, M.D., M. O. Scamahorn, M.D.

Richard Fairchild, attorney and James A. Waggener, executive secretary.

Minutes of the August 17th meeting were approved as amended on motion of Drs. Corcoran and Steen, the amendment being to delete next to the last sentence of item "p" under organization matters and inserting in lieu thereof the following: It was the opinion that we should offer our assistance and maintain an interest in the activities of this organization.

Membership Report

Full dues paying	3,888
Interns and residents	100
AMA full dues paying	3,741
Full dues paying as of August 31, 1967	3,855
Interns and residents as of August 31, 1967	102

Headquarters Office

The secretary presented for consideration a proposal for the installation of recording equipment in the office and a special telephone line which would be made available for the use of councilors, officers and commission chairmen for the purpose of dictating material to be produced by the headquarters staff in order to lighten the burden of correspondence for these individuals. On motion of Drs. Steen and Larson, this proposal is to be referred to the Council for their consideration.

A letter from Dr. Roland Miller to Dr. G. O. Larson concerning making the facilities and staff secretaries of the headquarters office available to the Academy of Pediatrics was read and on motion of Drs. Larson and Corcoran, Doctor Miller is to be advised we would be happy to do so and furthermore, to offer other specialty groups this same service.

A notice from the Marion County Board of Review again denying our request for exemption of property tax was read for the information of the committee.

Treasurer's Office

On motion of Drs. Hoyt and Larson, the treasurer's report was approved as presented and the request was made that in future reports, the investment account be broken down to show where these investments are placed.

Organization Matters

A letter from the Attorney General's office in reply to a patient who had complained about a hospital refusing to discharge a patient until the hospital account was paid was read for the information of the committee.

The request of Ivy Tech to use the association mailing list for the purpose of conducting a survey on health manpower was approved on motion of Drs. Larson and Corcoran.

A brochure on the National Association of Foreign Medical Graduates was reviewed and by consent it was agreed to request Doctor Donesa to meet with the Executive Committee at Fort Wayne on October 14.

A letter from Hamill & Price concerning the suit against Blue Cross was read for the information of the committee.

A letter from Doctor Rifner, addressed to the Dean of the I.U. School of Medicine, together with his reply, was read for the information of the committee.

Minutes of the meeting of the Blue Cross Executive Committee announcing a subsidy of $15,000 per year to the Indiana Licensed Nursing Home Association was reviewed for the information of the committee.

A report from Ball State University concerning the recent Drug Abuse Program, in which the association had financed a speaker on this subject, was reviewed for the information of the committee.

Correspondence between the Indiana State Board of Health and out-of-state Comprehensive Health Planning groups was reviewed for the information of the committee.

A letter from the Massachusetts Medical Society announcing their intention of nominating Doctor Eversole for vice-speaker of the House of Delegates of the AMA was reviewed for the information of the committee.

A letter from the Oregon Medical Association announcing their intention of nominating Dr. Max H. Parrott to succeed himself as a trustee of the AMA was read for the information of the committee.

Annual Convention — Fort Wayne, October 15-18, 1968

The request of the Convention Arrangements Committee for $100 to finance the golf program at the Fort Wayne meeting was approved on motion of Drs. Kintner and Larson. Doctor Corcoran added the request that the committee be requested to furnish a census of the number of physicians who participated in the golf program.

By consent, it was approved that the honorarium for speakers before the sections be paid $100 and any additional expenses would be the responsibility of the sections.

The secretary reviewed the President's Dinner and Reception and by consent it was agreed that a $10.00 per person charge be made for this event.

The secretary called attention to the fact that a Council breakfast had not been previously scheduled for Friday morning and asked if one should be scheduled. It was agreed that a breakfast would be held Friday morning at 7:30 a.m.

The secretary mentioned that all exhibit space had been sold.

The matter of the '69 meeting headquarters being the Columbia Club and the dates being October 13-16 was discussed and this information is to be referred to the Council.

New Business

A request of the Indiana State Association of Medical Assistants for approval of proposed changes in their bylaws was reviewed and on motion of Drs. Larson and Steen, the changes were approved.

A letter from Dr. James E. Bowes of the Pitman Moore Company concerning the eradication of measles program was read and on motion of Drs. Larson and Steen, this is to be referred to the appropriate commission of the association.

A letter from Stewart-Carey Company through the insurance carrier for the building, informing the association that they were unable to obtain Screenlok glass for replacement of the broken glass in the entrance lobby, but offering to replace with a Parallel-O-Gray polished plate and this offer was accepted by consent.

Future Meetings

On motion of Drs. Larson and Kintner it was agreed to accept Doctor Bowen's recommendation that we offer to send to the National Congress on Quackery in Chicago on October 2-3 the following:

Doctor Bowen, Dr. Floyd Coleman and Mr. Robert Bales and in case Mr. Bales would not accept, Mr. Ralph Heiney of Columbia City.

The AMA Congress on Medical Ethics, October 5-6. On motion of Drs. Larson and Kintner, it was approved that one of the attorneys be sent to this meeting.

The annual meeting of the State Chamber of Commeree to be held in French Lick on October 17-19 was reviewed for the information of the committee.

There being no further business, the committee adjourned to meet again at 10:00 a.m. Monday, October 15, 1968 in the President's Room in the Chamber of Commerce Building in Fort Wayne, Indiana. ◄

Another Myth Dispelled

Despite the proven value of safety belts in reducing injury and in saving an estimated 8,000 to 10,000 lives every year on our highways, myths about the *dangers* still persist.

One such myth which expresses a fear that seat belts cause severe abdominal injuries should be laid to rest permanently by findings of a new study made by the Automotive Crash Injury Research Project of Cornell Aeronautical Laboratory. The study showed that a significant risk of injury rarely exists from seat belts, except in accidents in which the individual would almost certainly be severely injured or killed if he were not wearing a seat belt.

Abdominal injuries occurred in five percent of the accidents studied, but 90% of those injuries were minor and superficial. In fact, only one-half of one percent of those injuries were severe and, undoubtedly, most of those injuries would have been listed under the fatalities column if it were not for the fact that the injured person was wearing a seat belt.

AMA

22ND CLINICAL CONVENTION

MIAMI BEACH

DECEMBER 1-4, 1968 · CONVENTION HALL

. . . the American "Riviera." Where glittering luxury hotels tower above glamorous Collins Avenue; and medicine, sea and sunshine mix in a delightful subtropical setting.

Register now, and be on hand for the world's largest winter medical meeting—the AMA's 22nd Clinical Convention. At this midwinter "summer" session in medicine there will be Three Postgraduate Courses: Fluid and Electrolyte Balance, Diabetes, and Hyperthyroidism in the Elderly Patient • 17 Scientific Sessions • Breakfast Roundtable Conferences • Color Television • and Medical Motion Pictures. The modern, air-conditioned Convention Hall will house hundreds of scientific and industrial exhibits to show you the very latest in equipment, services and drugs.

Plan now to join your colleagues in Miami Beach. Be sure to look for the complete scientific program, plus forms for advance registration and hotel accommodations in the October 21st issue of JAMA.

COMMERCIAL ANNOUNCEMENTS

BUY AND TRY: Wye Plantation Aberdeen-Angus frozen semen from Advanced Register P.R.I. sires officially gaining over four pounds per day or whose 365-day weights are above 1,200 pounds. (Performance tested sires always for sale.) WYE PLANTATION, Queenstown, Maryland 21658. Telephones: 301-827-7166 or 301-827-7160.

WANTED: In a college community, an associate or partner for a large medical practice. No surgery or OB. General practice can be done if desired. X-ray and laboratory facilities in the office. If desired, will consider sale. Write Box 344, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

PEDIATRICIAN: Salary to $18,000 first year, partnership with 3 general practitioners second year. Midwest university town; 600-bed hospital; intern program. Contact L. L. Wince, M.D., Children's Clinic, 806 W. Jackson St., Muncie, Ind. 47305.

WANTED: G. P. for New Castle; replacement in four-man group. Starting guarantee at least $35,000 first year; then partnership with increase. Rotating schedule; on duty less than 50% of the time. Call (317) 529-6250, Henry County Clinic.

WANTED: Two general practitioners to join two general practitioners in a large well-established practice of over 30 years in a town with population of 800 and covers large rural area of approximately 5,000. Location is 50 miles north of Minneapolis, Minnesota in excellent fishing and hunting area with golf, bowling and other recreation also available. Have local community hospital, medicare approved and equipped for general medicine and major and minor surgery. Salary negotiable, partnership available. New clinic planned. For references contact Dr. Gerald Larson, Cambridge, Minnesota; Dr. Joe Halpin, Rush City, Minnesota; Dr. Richard Varco, Dept. of Surgery, University of Minn. Medical School, Minneapolis, Minnesota; Dr. Dean Rizer, Internist, Medical Arts Building, Minneapolis, Minnesota; Dr. Paul Larson, OB-Gyn, Medical Arts Building, Minneapolis, Minnesota. If interested send application and references to Braham Clinic, Attn: Wm. T. Nygren, M.D., Braham, Minnesota 55006 or phone area code 612-396-3355 between hours of 10-12-A.M. or 1-5 P.M. Monday thru Friday. If after hours phone 612-396-2153. May call collect. If acceptable, expenses for personal interview will be allowed.

WANTED: Quiet, progressive community of 7,000 in East Central Indiana needs more general practitioners. Within 25 minutes of three hospitals. Three doctors in area now. Excellent educational system. Within 1½ hours of Indianapolis, Dayton, Cincinnati. May we send you more information? Community Medical Services Council, Box 222, Cambridge City, Indiana 47327.

PSYCHIATRIC RESIDENCIES: Starting July 1969. Approved training in a mental institution with State of Michigan, Department of Mental Health. Three and five year programs available. Salary $9,876-$11,233 and $11,254-$21,381. NIMH-GP stipends $12,000. Located in Michigan's serene, scenic recreation area on Grand Traverse Bay. For additional information, contact Dr. Paul Kauffman, Training Director, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

FOR SALE: Examination tables, supply cabinets, electric typewriter, file cabinets, secretary's desks and chairs, etc., at any reasonable offer. 23 E. Ohio St., Suite 920, Indianapolis, Ind. 46204. Phone 632-4557 or 293-0259.

FOR SALE: New medical office and equipment of Dr. M. J. Kielton, (recently expired). Seven-room office with two baths, full basement, 1923 sq. ft. Nicely appointed reception room and doctor's office and consultation room, three treatment rooms, large business office and nurse's station and laboratory. The building has central heating and air-conditioning. This office must be seen to be appreciated. Lot is 200' x 132' with large blacktopped parking area. Medical records of the office are available, if so desired. Contact the St. Joseph Valley Bank, Elkhart, Indiana, Trust Dept.-Co.-Executor of the estate of Melvyn J. Kielton, M.D. 1333 W. Lusher Ave., Elkhart, Ind. or call 522-3640.

NINETEEN-MAN Wisconsin group located in college community of 40,000 with excellent hospital facilities is seeking additional associates in the following areas:

1. Internal Medicine
2. Urology
3. General Practice
4. Pediatrics

For further information, please contact D. R. Griffith, M.D., Midelfart Clinic, Eau Claire, Wis. 54701.

EMERGENCY ROOM PHYSICIAN: Excellent opportunity for young physician interested in full-time practice of emergency room care. Join a physician group responsible for the emergency service of two major Cincinnati hospitals. Remuneration on a fee-for-service basis with guaranteed minimum. Must have or be eligible for Ohio license. Send resume to P. O. Box 36163, Cincinnati, Ohio 45236.

NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

Charges for commercial announcements are:

First four lines: $3.00
each additional line: 50¢

Send cash with order. Average count: seven words to the line.

DEADLINE: Fifth day of month PRECEDING month of issue.

ADVERTISERS IN THIS ISSUE

November 1968 Volume 61 No. 1

Associated Credit Bureaus of Indiana 1607
Breon Laboratories, Inc. 1609
Brown Pharmaceutical Co. 1584
Burroughs Wellcome & Co., Inc. 1521
Campbell Soup Company 1559
Geigy Pharmaceuticals 1524-26, 1568-72, 1600-02
Hanger, J. E., Inc. 1594
Harding Hospital 1590
Highland Hospital 1582
Home Lawn Mineral Springs 1588
Hynson, Westcott & Dunning, Inc. 1501
Indiana Medical Bureau 1603
Lederle Laboratories 1503, 1514-15, 1546, 1586-87, 1595, 1599, 1605
Lilly, Eli & Company 1510-11, 1530, 1562
Medical Protective Co. of Ft. Wayne 1577
Merck, Sharp & Dohme .....2nd Cover
Mutual Medical Insurance, Inc. 1519
National Drug Company 151
Parke, Davis & Company 158
Pitman-Moore Company 1592-9
Poythress, Wm. P. & Co., Inc. 160
Robins, A. H. Company, Inc. 1535-36, 158
Roche Laboratories .....4th Cover, 1522-23, 158
Rorer, William H., Inc. 159
Sandoz Pharmaceuticals 1507, 156
Searle, G. D. & Co. 1560-6
Strasenburgh Laboratories 154
Stuart Company, The 150
Wabash Valley Hospital 152
Warner-Chilcott Laboratories 150
Warren-Teed Pharmaceuticals 1578-7
WFBM-TV 159
White-Haines Optical Co. 158
Winthrop Laboratories 151
Wyeth Laboratories .....3rd Cove

In accepting advertising for publication, *The Journal* has exercised reasonable precaution to insure that only reputable factual advertisements are included. However, we do not have facilities to make any comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services, and medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertiser only. Neither sanction nor endorsement of such is warranted, stated, or implied by the association.

The JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION

Indianapolis, Indiana
December, 1968
Vol. 61 • No. 12

U.C. MEDICAL CENTER LIBRARY
JAN 2 1969
San Francisco 22

J-O-P
Univ. Of Calif
Med Ctr Library
Acquisitions Dept
San Francisco, Calif 94122
12-68

Coming home is wonderful

when you have

Blue Cross–Blue Shield

Mutual Hospital Insurance, Inc. Mutual Medical Insurance, Inc.
Home Office: 110 N. Illinois St., Indianapolis, Indiana 46204

When you're young and healthy, you think the bad things mostly happen to other people. But accidents and illness do happen to the young and healthy, and many times that includes long hospital stays as well as continuing doctors visits.

That's why we say: coming home is wonderful, when you have Blue Cross–Blue Shield to take over most of the financial worries.

For today's good health care does cost money. And that makes it more important than ever to have Blue Cross–Blue Shield, the health care plan that gives you the most, dollar for dollar, benefit for benefit.

Remember that the health care field is Blue Cross–Blue Shield's business—their only business. They do the job more efficiently than anyone else, handling things directly with hospitals and with doctors, never bothering members or employers.

This is one major reason why over 2,000,000 Hoosiers and 10,000 business firms are served by Indiana's No. 1 health care plan. Lots of them say the same thing:

"I don't know what we would have done without Blue Cross–Blue Shield."

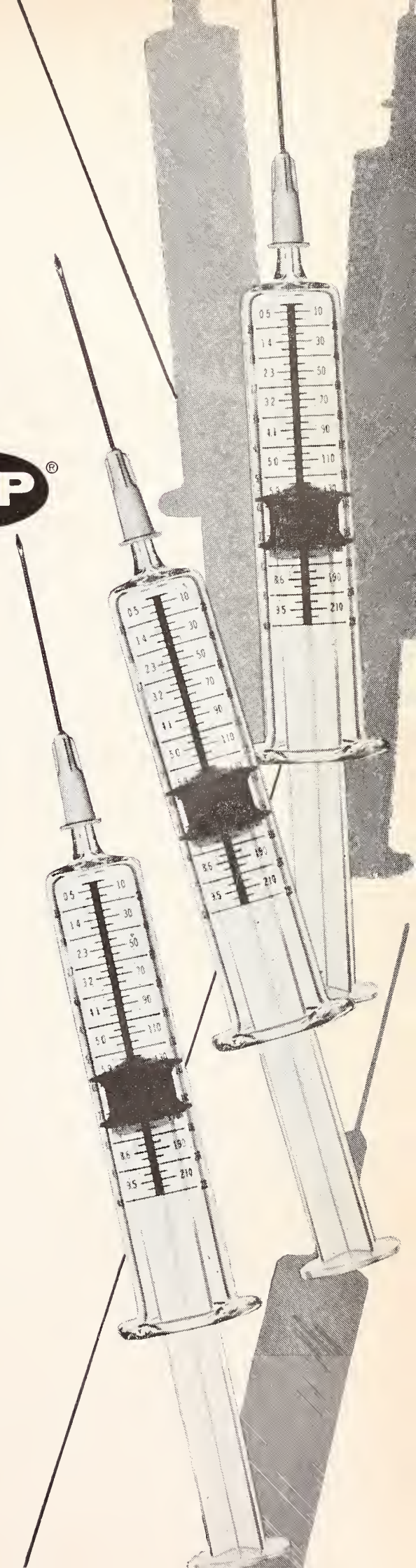
(One of a series of ads being run in key Hoosier newspapers)

BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)

BSP®



BROMSULPHALEIN®

IN A COMPLETE,

STERILE,

DISPOSABLE,

& ECONOMICAL

PATIENT-UNIT.

BSP, one of the more valuable single laboratory procedures for determining hepatic function, is now packaged in a complete individual patient-unit.

The BSP Disposable Unit contains a sterile syringe with the dosage schedule imprinted on the barrel, a sterile needle, alcohol swab and a 7.5 ml. or 10 ml. size ampule of terminally sterilized BSP solution. Each unit contains complete directions for use, precautions and contraindications.

This all-inclusive disposable put-up lessens the chance of cross-infection and saves time and labor — the most costly commodities.

HYNSON, WESTCOTT & DUNNING, INC.

(BSP03)

BALTIMORE, MARYLAND 21201

DECEMBER 1968

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Office of Publication

3935 N. Meridian, Indianapolis, Indiana 46208

Contents

SCIENTIFIC

Commercial Supersonic Transportation and the Patient, Robert B. Stonehill, M.D., Raymond H. Murray, M.D., Indianapolis 1645

A New Solubility Test for Rapid Detection of Hemoglobin S, Wei-Ping Loh, M.D., Gary 1651

Infections Encountered in Tornado and Automobile Accident Victims, John H. Ivy, M.D., Elkhart 1657

Electrocardiogram of the Month: PAT with Block Due to Digitalis, Charles Fisch, M.D., Indianapolis 1662

X-Ray Conference: Diagnosis of Metastatic Disease to the Obturator Nodes in Carcinoma of the Cervix, Erich K. Lang, M.D., Shreveport, La. 1664

EDITORIALS

Partners of the Alliance 1666

Second Interim Report of the HEW Task Force on Prescription Drugs 1666

Fifty-Year Club Response, J. O. Ritchey, M.D., Indianapolis 1667

The Chicago Convention and Socialized Medicine (Guest) 1668

Medical Ethics (Guest) 1668

Editorial Notes 1668

SPECIAL FEATURES

New Zoning Ordinance Creates Hospital Districts 1670

1968 CONVENTION

1968—The Convention Story 1701

1910 Physician's Office Highlight of Fort Wayne, Jackie Stahl, Assistant Editor, The Journal 1722

Convention Election Results: Dr. Lowell H. Steen is Named President-Elect 1724

The Winners 1725

American Medicine Leads the Way, Dwight L. Wilbur, M.D., San Francisco, Calif... 1726

REGULAR FEATURES

President's Page 1625

Month in Washington 1628

What's New? 1637

Letters to the Editor 1638

Fourth Estate 1640

Wanted: Physicians, Locations 1672

Medicine at Law 1674

Blue Shield Report to ISMA House of Delegates (One of a Series) 1678

Board of Health Report 1680

Future Meetings, Seminars, Courses 1681

Abstracts, Book Reviews 1682

News Notes 1686

From The Journal 50 Years Ago 1692

Deaths 1698

Annual Meeting Dates of Professional Medical and Allied Organizations 1699

County, District News 1700

BUSINESS

Executive Committee:

Oct. 14, 1968 1730

Oct. 18, 1968 1731

The Council:

Aug. 17, 1968 1731

Aug. 18, 1968 1739

Oct. 14, 1968 1748

Oct. 18, 1968 1754

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, dauble-spaced with margins af one inch.

Phatagraphs shauld be printed an glassy paper. Negatives cannot be used.

Illustratians are desirable. Selectian af illustratians submitted at discretian af editar and editorial baard members.

Cantributars are responsible for all statements made in their articles. The editars and editorial baard members may nat be in agreement with all views expressed by authars, but it is desired to give all authars as great latitude as passible.

Articles are accepted for publicatian with the understanding that they are submitted for exclusive publicatian.

Cammunicatians dealing with editarial matter shauld be sent to Frank B. Ramsey, M.D., Editar, 1802 Narth Illinais Street, Indianapolis 46202. All ather cammunicatians shauld be sent ta THE JOURNAL af the Indiana State Medical Assaciatian, 3935 N. Meridian, Indianapalis 46208.

Advertising rates will be furnished an request. Capy must be received by the 5th af the manth preceding manth af issue. (Scientific manuscripts must be received at least twa weeks earlier if geared far a specific issue.)

Representative far natianal advertising is the State Medical Journal Advertising Bureau, 510 N. Dearborn St., Chicaga, Ill.

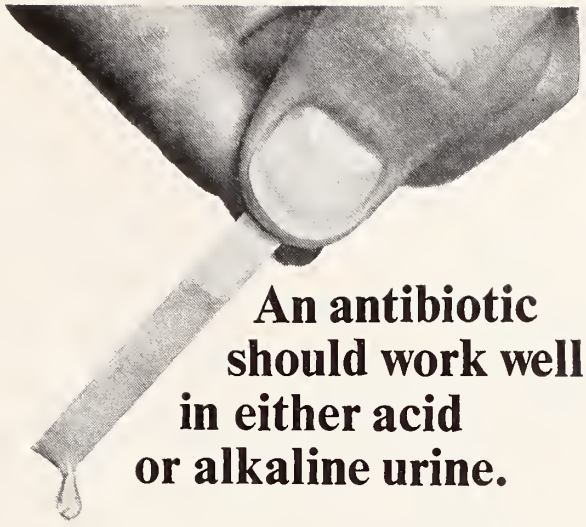
Entered as secand class matter January 25, 1933, at the Pastoffice at Indianapalis, Indiana. Capyright, 1968 by the Indiana State Medical Assaciatian. Published manthly at 3935 N. Meridian, Indianapolis 46208.

Secand-class pastage paid at Indianapalis, Indiana and at additianal mailing affice.

All issues af 1967 and subsequently may be abtained an microfilm. Address The Jaurnal for details.

About Our Cover

on page 1632.



An antibiotic should work well in either acid or alkaline urine.

It isn't always necessary to adjust urinary pH in treating G.U. infections.

Not when the causative organism is a strain sensitive to DECLOMYCIN® Demethylchlortetracycline, as is often the case.

DECLOMYCIN remains stable and active in either acid or alkaline urine. So there's no need to acidify the urine to keep the antibiotic at work.

Why match the urine to the antibiotic...when you can match the antibiotic to the urine...by prescribing DECLOMYCIN. A b.i.d. dosage makes therapy convenient for your patient.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system – anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin – maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney – rise in BUN, apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions–urticaria, angioneurotic edema, anaphylaxis. Teeth – dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; Tablets: film coated – 300 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

355-8

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545

ANNUAL CONVENTION—OCTOBER 13-16, 1969—INDIANAPOLIS

OFFICERS FOR 1968-69

President—Patrick J. V. Corcoran, 3700 Bellemeade, Evansville 47715.

President-Elect—Lowell H. Steen, 2450 169th St., Hammond 46323.

Treasurer—Lester H. Hoyt, M.D., Methodist Hospital, Indianapolis 46202.

Assistant Treasurer—Malcolm O. Scamahorn, Pittsboro 46167.

Executive Secretary—Mr. James A. Waggener, 3935 N. Meridian, Indianapolis 46208.

TRUSTEES

District	Term Expires
1—Gilbert M. Wilhelmus, Evansville	Oct. 1971
2—Joe Dukes, Dugger	Oct. 1969
3—Donald M. Kerr, Bedford	Oct. 1970
4—Robert M. Reid, Columbus	Oct. 1971
5—Wilbert McIntosh, Riley	Oct. 1969
6—Stephen D. Smith, Knightstown	Oct. 1970
7—James H. Gosman, Indianapolis	Oct. 1971
8—Donald R. Taylor, Muncie (Chairman)	Oct. 1969
9—Peter R. Petrich, Attica	Oct. 1970
10—Vincent J. Santare, Munster	Oct. 1971
11—Lowell Hillis, Logansport	Oct. 1969
12—William R. Clark, Fort Wayne	Oct. 1970
13—Otis R. Bowen, Bremen	Oct. 1971

ALTERNATES

District	Term Expires
1—Eugene Austin, Evansville	1970
2—Betty Dukes, Dugger	1971
3—Elmer L. Wallace, New Albany	1971
4—Jack E. Shields, Brownstown	1970
5—Cleon M. Schauwecker, Greencastle	1970
6—Frank Green, Rushville	1969
7—John O. Butler, Indianapolis	1969
8—Paul Sparks, Winchester	1970
9—Lindley Wagner, Lafayette	1971
10—Charles T. Disney, Gary	1969
11—James A. Harshman, Kokomo	1971
12—Frederic L. Schoen, Fort Wayne	1971
13—G. Beach Gattman, Elkhart	1970

SECTION OFFICERS 1968-69

Section on Surgery:
Chairman—Henry Larzelere, Marion
Vice-chairman—Austin Gardner, Indianapolis
Secretary—Robert Rang, Washington

Section on Internal Medicine:
Chairman—Louis Sandock, South Bend
Vice-chairman—Evart M. Beck, Indianapolis
Secretary—Robert L. Rudesill, Indianapolis

Section on Ophthalmology and Otolaryngology:
Chairman—David E. Brown, Indianapolis
Vice-chairman—Kenneth F. Isenogle, Fort Wayne
Secretary—George A. Clark, Indianapolis

Section on Anesthesiology:
Chairman—Robert W. Vermilya, Lafayette
Vice-chairman—William M. Sholty, Lafayette
Secretary—Adolph P. Walker, East Chicago

Section on General Practice:
Chairman—Robert W. Mouser, Indianapolis
Vice-chairman—Richard Juergens, Fort Wayne
Secretary—Robert Acher, Greensburg

Section on Obstetrics and Gynecology:
Chairman—Tom W. Wachob, Jr., Kokomo
Vice-chairman—Charles R. Echt, Indianapolis
Secretary—Barton T. Smith, Marion

Section on Public Health and Preventive Medicine:
Chairman—Bertram F. Duckwall, Terre Haute
Vice-chairman—
Secretary—Louis E. How, South Bend

Section on Radiology:
Chairman—John A. Robb, Indianapolis
Vice-chairman—Robert E. Beck, Evansville
Secretary—Dale B. Parshall, Elkhart

Section on Nervous and Mental Diseases:
Chairman—Robert O. Bill, Indianapolis
Vice-chairman—Richard L. Shriner, South Bend
Secretary—Wesley A. Kissel, Indianapolis

Section on Pathology:
Chairman—Robert J. Frost, Michigan City
Vice-chairman—
Secretary—Robert L. Costin, Indianapolis

Section on Pediatrics:
Chairman—Roland E. Miller, Lafayette
Vice-chairman—Gustaf W. Erickson, South Bend
Secretary—Morris Green, Indianapolis

Section on Directors of Medical Education:
Chairman—Donald T. Olson, South Bend
Vice-chairman and Secretary—Franklin A. Bryan, Fort Wayne

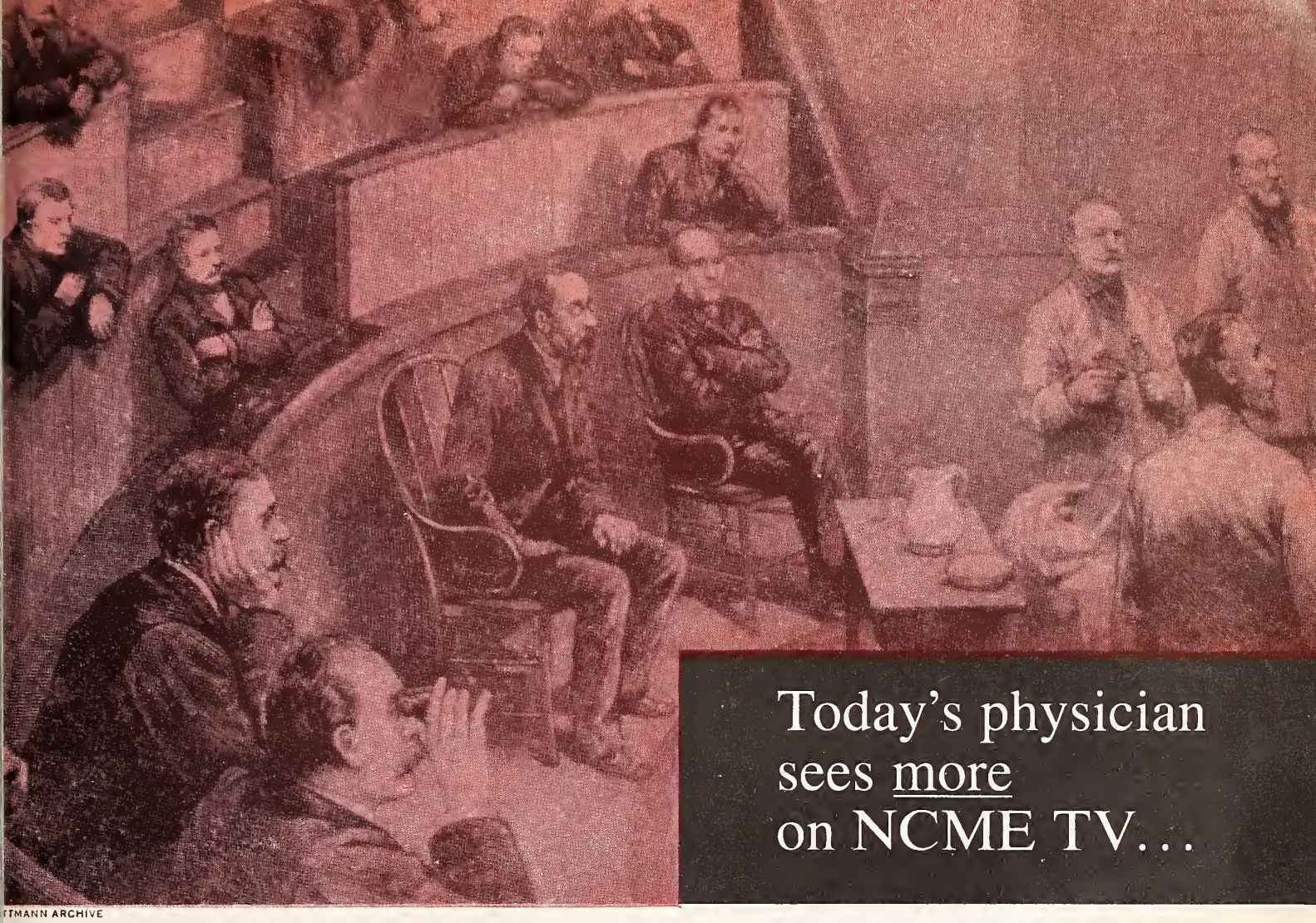
DELEGATES TO THE AMA

Terms expire December 31, 1969:

Delegates	Alternates
Guy A. Owsley Hartford City	Maurice E. Glock Fort Wayne
Jack E. Shields Brownstown	Dwight W. Schuster Indianapolis

Terms expire December 31, 1970:

Delegates	Alternates
Don E. Wood Indianapolis	James A. Harshman Kokomo
Eugene F. Senseny Fort Wayne	Eugene S. Rifner Van Buren
Frank H. Green Rushville	Kenneth O. Neumann Lafayette



Today's physician sees more on NCME TV...

TMANN ARCHIVE

The first nationwide medical television service, NCME—The Network for Continuing Medical Education—brings you visually the important achievements of leading medical authorities. By means of closed-circuit television, this independent network provides your hospital or medical school with a complete videotape service that helps shorten the gap between new medical knowledge and its availability for clinical or teaching purposes.

NCME The Network for Continuing Medical Education

NCME TV Offers These Practical Benefits:

☐ Every two weeks a new 60-minute videotape dealing with three separate medical subjects is sent to participating institutions.

☐ Content and format of NCME telecasts fulfill criteria for postgraduate medical education, permitting American Academy of General Practice course credits under specified conditions.

☐ To help your institution make effective use of closed-circuit television, NCME offers a wide range of services and utilization aids, including: Technical consultation in setting up a closed-circuit system; advance program information on the contents of each telecast; display units to help publicize programs; expense-paid seminars to improve utilization of medical television.

☐ NCME programs are brief and may be shown as often as desired; you can view the telecasts at times that are most convenient, without disrupting your normal schedule.

☐ Frequently NCME makes available published papers related to subjects presented on closed-circuit television.

A recent NCME hospital telecast presented Philip N. Sawyer, M.D., Professor of Surgery and Head of the Vascular Surgical Service at Downstate Medical Center, Brooklyn, N.Y., in a demonstration and evaluation of "Gas Endarterectomy."

In this program, Dr. Sawyer performs the operation on a patient with gross occlusion of the right iliac, femoral and popliteal arteries.

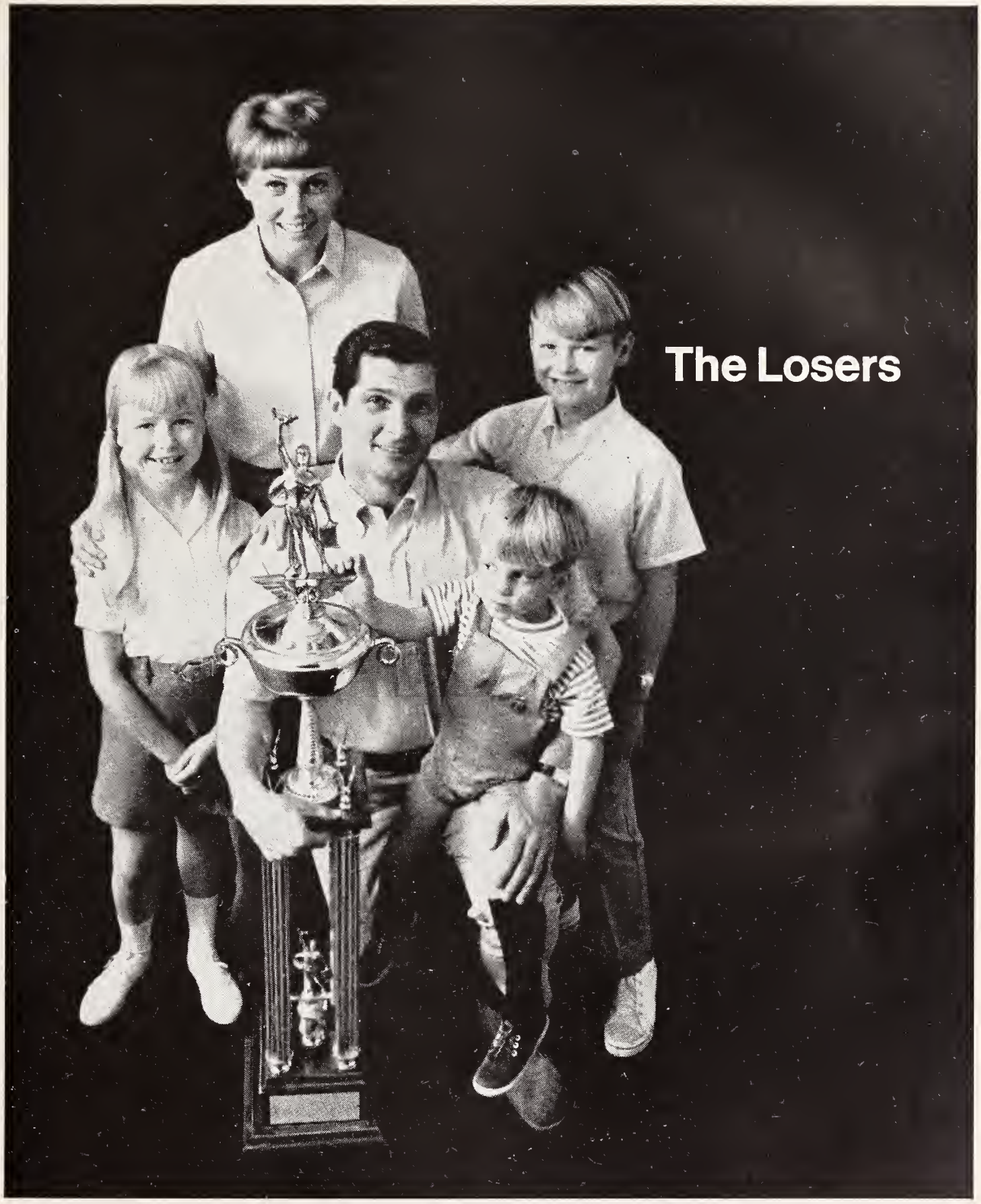
In Dr. Sawyer's view, gas endarterectomy has several advantages over mechanical methods: the operation can be completed faster, causes less damage to the arteries and offers a more successful outcome.

NCME is an independent network supported by Roche Laboratories to increase the use of closed-circuit TV for medical education under direct hospital and school control.

If your hospital or school does not participate in the biweekly NCME program, information on the cost-free service may be obtained by writing to NCME, 342 Madison Avenue New York, N.Y. 10017

COUNTY MEDICAL SOCIETY DIRECTORY

COUNTY	PRESIDENT	SECRETARY
Adams	Arthur H. Girod, Decatur	Harold F. Zwick, 227 S. Second St., Decatur
Allen (Fort Wayne)	Frederic L. Schoen, Fort Wayne	Eugene E. Schmidt, Suite 725, Indiana Bank Bldg., Fort Wayne
		Mr. Larry L. Pickering, Exec. Secy., 212 Med. Ctr. Bldg., Fort Wayne
Bartholomew-Brown	Harold W. Richmond, Columbus	C. David Ryan, 2600 Sandcrest Blvd., Columbus
Benton	A. L. Coddens, Earl Park	D. L. McKinney, Box 398, Otterbein
Boone	James R. McAfee, Lebanon	Katherine A. Jackson, 95 E. Oak St., Zionsville
Carroll	Marilyn L. Wagoner, Burlington	Robert Seese, 101 W. North St., Delphi
Cass	Joseph S. Bean, Logansport	Edward L. TerBush, 216 Ninth Street, Logansport
Clark	Robert K. McKechnie, Jeffersonville	Hassi Shina, Charlestown
Clay	J. Frank Maurer, Brazil	Forrest R. Buell, 314 Lankford St., Clay City
Clinton	Bruce A. Work, Frankfort	George K. Hammersley, 361 E. Clinton St., Frankfort
Daviess-Martin	A. G. Blazey, Washington	Hamlin B. Lindsay, 511 E. Main St., Washington
Dearborn-Ohio	Fred D. Houston, Lawrenceburg	Leslie M. Baker, 501 Fourth St., Aurora
Decatur	Dale D. Dickson, Greensburg	Arnold D. Ducanes, 215 N. Franklin St., Greensburg
DeKalb	John C. Harvey, Auburn	C. Bishop Hathaway, 209 N. Jackson St., Auburn
Delaware-Blackford	Glynn A. Rivers, Muncie	Richard N. Philbert, 2810 Ethel Ave., Muncie
Dubois	H. G. Backer, Ferdinand	John Bretz, 302-14th St., Huntington
Elkhart	Philip G. Bowser, Goshen	Page E. Spray, 320 W. High St., Elkhart
Fayette-Franklin	B. W. Sanders, Connersville	J. L. Steinem, 818 Grand Ave., Connersville
Floyd	William F. Ruoff, New Albany	Daniel H. Cannon, 1201 E. Spring St., New Albany
Fountain-Warren	Max N. Hoffman, Covington	Theodore Person, 601 N. Mill St., Veedersburg
Fulton	Joseph D. Richardson, Rochester	r. Richard Walton, 116 W. 9th St., Rochester
Gibson	William E. Dye, Oakland City	David H. Lindauer, 115 N. Prince St., Princeton
Grant	J. C. Jarrett, Marion	Robert G. Young, 1207 Northwood Ct., Marion
Greene	Robert Moses, Worthington	Harry Rotman, Jasonville
Hamilton	John S. Hash, Noblesville	H. R. Blackburn, Riverview Hospital, Noblesville
Hancock	John J. Farrell, Greenfield	Joseph A. Miller, Oaklandon
Harrison-Crawford	Carl Dillman, Corydon	Richard A. Jordan, Corydon
Hendricks	Eli Coats, Indianapolis	Carl J. Heinlein, 637 E. Main, Danville
Henry	Guido P. Wilhelm, New Castle	Paul T. KinKade, 1015 Broad St., New Castle
Howard	John L. Frazier, Kokomo	John H. Elleman, 416 W. Mulberry St., Kokomo
Huntington	Wayne S. Miller, Huntington	Stanton E. Cope, 1022 N. Jefferson St., Huntington
Jackson-Jennings	Kenneth E. Bobb, Seymour	William F. Blaisdell, 207 N. Pine, Seymour
Jasper	Ernest R. Beaver, Rensselaer	Francis E. O'Brien, McKinley and Washington Sts., Rensselaer
Jay	Ralph Steffy, Portland	Elizabeth Tate, 317 S. Main St., Dunkirk
Jefferson-Switzerland	Elton Heaton, Madison	Ott B. McAtee, Madison State Hospital, Madison
Johnson	George Brown, Greenwood	Charles Link, 365 E. Main St., Greenwood
Knox	Charles L. Miller, Vincennes	Daniel J. Combs, 1325 McDowell Rd., Vincennes
Kosciusko	Wymond B. Wilson, Mentone	Arthur L. Moser, 600 Winona, Warsaw
LaGrange	Michael O. Mellinger, LaGrange	Allen S. Martin, Box 3A, Shipshewana
Lake	Seymour W. Shapiro, Gary	Reginald R. Barton, 7737 Forrest Ave., Gary
		Mr. John B. Twyman, Ex. Dir., 4640 W. 5th Ave., Gary
LaPorte	William E. Wolf, LaPorte	James J. J. Sprecher, 1001 Maple Ave., LaPorte
		Mrs. Polly Dent, Exec. Dir., 903 Indiana Ave., LaPorte
Lawrence	George W. Sorrells, Bedford	Reid C. Crosby, 11 Saddler Ct., Bedford
Madison	John R. Wagoner, Anderson	William M. Stinson, 333 Jackson St., Anderson
Marion	Hugh K. Thatcher, Indianapolis	A. Alan Fischer, 3500 Lafayette Rd., Suite 203, Indianapolis
		Mr. Arthur G. Loftin, Exec. Secy., 211 N. Delaware St., Indianapolis
Marshall	James Hampton, Argos	Harry Stoller, 109 N. Walnut St., Plymouth
Miami	Parker W. Snyder, Peru	Gordon S. Crates, Denver
Montgomery	V. G. Viray, Crawfordsville	W. E. Shannon, 408 W. Market St., Crawfordsville
Morgan	George Ostheimer, Martinsville	Maurice A. Turner, 10½ N. Main St., Martinsville
Newton	John Parker, Goodland	Arthur Schoonveld, Brook
Noble	O. Thomas Slough, Kendallville	Joseph Greenlee, Avilla
Orange	Charles X. McCalla, Paoli	Phillip T. Hodgin, Orleans
Owen-Monroe	Brad Bomba, Bloomington	Glen D. Ley, 400 E. Third St., Bloomington
Parke-Vermillion	John Somerville, Clinton	Milton Herzberg, Clinton
Perry	Robert Gilbert, Tell City	Gene E. Ress, 507 Main St., Tell City
Pike	M. H. Omstead, Petersburg	M. H. Omstead, Petersburg
Porter	John E. Read, Chesterton	Milton R. Carlson, 14000 Central, Portage
Posey	Paul Boren, Poseyville	Herman Hirsch, 130 W. 5th St., Mt. Vernon
Pulaski	Henry R. Eshelman, Monterey	E. L. Hollenberg, 613 Tippecanoe Dr., Winamac
Putnam	James B. Johnson, Greencastle	Anne S. Nichols, 707 E. Seminary, Greencastle
Randolph	Howard W. Koch, Winchester	Paul W. Sparks, 214 S. Main St., Winchester
Ripley	Bill E. Freeland, Batesville	William J. Warn, Milan
Rush	Donald I. Dean, Rushville	Charles E. Sheets, Manilla
St. Joseph	Jacob Rosenwasser, Mishawaka	L. F. Sandock, 503 Sherland Bldg., South Bend
		Mr. Harry Davis, Exec. Secy., 106 W. Monroe, South Bend
Scott	Ignacio B. Castro, Shelbyville	Jesus C. Bacala, 69 Wardell St., Scottsburg
Shelby	P. M. Inlow, Shelbyville	R. P. Inlow, 103 W. Washington St., Shelbyville
Spencer	John C. Glackman, Jr., Rockport	Michael O. Monar, Rockport
Starke	Earl Leinbach, Hamlet	W. Allen Palmer, Knox
Steuben	Mary H. Cameron, Angola	Richard W. Artz, 416 E. Maumee St., Angola
Sullivan	M. H. Bedwell, Sullivan	J. S. Brown, Carlisle
Tippecanoe	Hugh Steele, Lafayette	Anson F. Hughes 2424 Ferry St., Lafayette
Tipton	Robert L. Haller, Kempton	Albert E. Stouder, Kempton
Vanderburgh	Ralph Carlson, Evansville	Mr. Arthur P. Tiernan, Exec. Secy., 109½ S. E. 3rd., Evansville
Vigo	John Freed, Terre Haute	Robert L. Meissel, 920 N. 19th St., Terre Haute
Wabash	Fred C. Poehler, LaFontaine	Frank Smyrniotis, 645 Spring St., Wabash
Warrick	Peter B. Hoover, Boonville	Robert C. Colvin, Newburgh
Washington	Eddie R. Apple, Salem	Truman L. Chastain, 906 W. Mulberry, Salem
Wayne-Union	John Stepleton, Richmond	John Dehner, Reid Memorial Hospital, Richmond
Wells	Charles Caylor, Bluffton	R. D. Willard, R. R. 4, Bluffton
White	W. M. Dickerson, Monticello	M. Ali Jehanyar, 116 N. Illinois, Monticello
Whitley	Verlin P. Huffman, S. Whitley	Thomas Hamilton, 115 S. Main St., Columbia City



They did it. They shaped up. They fought the losing battle and won.

And now they know what it takes to take it off.

They listened to a professional like you. Together they planned a losing strategy. Diet. Exercise. Rest. Will power. That's what made them physically fit. Not fad stuff or pot luck.

You can help others. Inform. Educate. Get them interested in school physical fitness programs. Make them understand that weight reduction and a trim physique just won't happen overnight.

Project Weight Watch can help, too. We have a complete portfolio of materials and suggested scientific diets available, free. The diets are a realistic balance of the 4 food groups—meat, breads and cereals, fruits and vegetables and dairy foods. Diets you'd write yourself if you had the time. Take a minute and send for them today.

PROJECT WEIGHT WATCH

FACTS, NOT FADS

The more they lose, the more they gain.

Name

Position

Address

City

State Zip

DAIRY COUNCILS OF INDIANA

EVANSVILLE - INDIANAPOLIS - SOUTH BEND

50 SOUTH PARKER, INDIANAPOLIS 46201

ISMA Committees and Commissions for 1967–1968

COMMITTEES

Executive
Ralph V. Everly, Indianapolis, chairman; Burton E. Kintner, Elkhart; P. J. V. Corcoran, Evansville, President; Lowell H. Steen, Hammond, President-Elect; Donald Taylor, Muncie, Chairman of the Board of Trustees; Lester H. Hoyt, Indianapolis, Treasurer; Malcolm O. Scamahorn, Pittsboro, Assistant Treasurer.

Grievance
Philip B. Reed, Indianapolis, chairman; Eugene S. Rifner, Van Buren, vice-chairman; Robert G. Young, Marion, secretary; Kenneth L. Olson, South Bend, Earl W. Mericle, Indianapolis; Richard Bloomer, Rockville; John M. Paris, New Albany; Wilson L. Dalton, Shelbyville; William R. Noe, Bedford.

Student Loan
G. O. Larson, LaPorte; Lester H. Hoyt, Indianapolis; Glenn W. Irwin, Indianapolis; Donald R. Taylor, Muncie; James O. Ritchey, Indianapolis; Lester D. Bibler, Indianapolis; Mr. Robert Robinson, Indianapolis.

Medical-Legal Review
Lall G. Montgomery, Muncie; Truman E. Caylor, Bluffton; E Rogers Smith, Indianapolis

COMMISSIONS

Aging
George M. Young, Gary, Chairman; A. W. Cavins, Terre Haute, Vice-Chairman; Raymond Duncan, Bedford, Secretary; Bernard B. Rosenblatt, Evansville; R. E. Buckingham, Bloomington; Walter S. Fisher, Columbus; Glen A. Ramsdell, Richmond; John O. Butler, Indianapolis; John Cullison, Muncie; Wallace R. Van Den Bosch, Lafayette; George W. Wagoner, Delphi; Nathan Salon, Fort Wayne; Donald T. Olson, South Bend; Andrew C. Offutt, Indianapolis; Wendell C. Anderson, Indianapolis.

Constitution and Bylaws
Gordon S. Fessler, Rising Sun, Chairman; William M. Sholty, Lafayette, Vice-Chairman; James F. Lewis, Liberty, Secretary; George W. Willison, Evansville; Thomas H. Gootee, Jasper; M. C. Topping, Terre Haute; Joseph F. Ferrara, Franklin; B. D. Wagoner, Union City; Chester L. Waits, Lafayette; O. L. Marks, East Chicago; Richard L. Glendening, Logansport; John S. Farquhar, Fort Wayne; Edwin C. Mueller, La Porte; Burton Kintner, Elkhart.

Convention Arrangements
Charles H. Aust, Fort Wayne, Chairman; Durward W. Paris, Kokomo, Vice-Chairman; William M. Kendrick, Mooresville, Secretary; Richard B. Hovda, Evansville; William F. Howard, Bloomington; Irvin Sonne, New Albany; Merritt O. Aicorn, Madison; John E. Freed, Jr., Terre Haute; John Mader, Richmond; Francis E. Stout, Muncie; Boyd A. Burkhardt, Tipton; John L. Ferry, Whiting; James D. Finfrock, Elkhart; Kenneth Kohlstaedt, Indianapolis; Charles Fisch, Indianapolis.

Governmental Medical Services
Charles Hendrix, Vincennes; Guy H. Waldo, Bedford; Herman Echsner, Columbus; Dick J. Steele, Greencastle; Tom S. Shields, Richmond; Robert P. Scott, Indianapolis; J. F. Hinchman, Parker; Ramon B. Dubois, Lafayette; Edward J. Dierolf, Gary; George D. Buckner, Fort Wayne; D. D. Swihart, Elkhart; Jerome E. Holman, Jr., Indianapolis; Glen V. Ryan, Indianapolis.

Inter-Professional Relations
Fred Flora, Frankfort, Chairman; Virgil E. Angel, Highland, Vice-Chairman; William S. Robertson, Spiceland, Secretary; A. Wayne Ratcliffe, Evansville; Philip R. Karsell, Bloomington; Charles X. McCalla, Paoli; John W. Ripley, Seymour; Richard L. Veach, Bainbridge; Willis W. Stogsdill, Indianapolis; Wendell Covalt, Muncie; H. H. Dunham, Wabash; Pierre C. Talbert, Bluffton; A. Alan Fischer, Indianapolis; Robert G. Husted, Munster.

Legislation
Dwight W. Schuster, Indianapolis, Chairman; Don E. Wood, Indianapolis, Vice-Chairman; Jack W. Hickman, Indianapolis, Secretary; Daniel M. Hare, Evansville; Harold Manifold, Bloomington; Elmer L. Wallace, New Albany; Leslie M. Baker, Aurora; Fred W. Dierdorf, Terre Haute; John Davis, Flat Rock; Guy A. Owsley, Hartford City; Max N. Hoffman, Covington; Daniel Ramker, Hammond; Lester Renbarger, Marion; Eugene F. Senseny, Fort Wayne; Otis R. Bowen, Bremen.

Medical Economics and Insurance
Thomas G. Hamilton, Columbia City, Chairman; Thomas J. Conway, Terre Haute, Vice-Chairman; Chester A. Stayton, Jr., Indianapolis, Secretary; Charles M. Sinn, Evansville; Paul W. Holtzman, Bloomington; Edward J. Ploetner, Jasper; William A. Johnson, North Vernon; David R. Cain, New Castle; James M. Leffel, Indianapolis; Charles E. Geckler, Muncie; Kenneth O. Neumann, Lafayette; A. S. Kobak, Valparaiso; Richard Wagner, Huntington; Jack W. Hannah, Elkhart; William J. Miller, Lafayette.

Medical Education and Licensure
James B. Johnson, Greencastle, Chairman; John L. Cullison, Muncie, Vice-Chairman; Forrest LaFollette, Hammond, Secretary; John Sterne, Evansville; Betty Dukes, Dugger; John M. Paris, New Albany; Richard A. Snapp, Columbus; Frank Coble, Richmond, George T. Lukemeyer, Indianapolis; William Ringer, Williamsport; Leo Radigan, Gary; Lowell J. Hillis, Logansport; Joel Salon, Fort Wayne; Jene R. Bennett, South Bend; Merritt O. Alcorn, Madison; Peter J. Pilecki, Michigan City; Glenn W. Irwin, Jr., Indianapolis.

Public Health
T. O. Middleton, Bloomington, Chairman; Henry G. Nester, Indianapolis, Secretary; Daniel Hare, Evansville; Roy L. Fultz, Salem; R. M. Seibel, Nashville; Cleon M. Schauwecker, Greencastle; Wilson L. Dalton, Shelbyville; Stanley W. Burwell, Muncie; Theodore C. Person, Veedersburg; Gilbert Z. Given, East Chicago; Paul Sparks, Winchester; Theodore J. Smith, Whiting; Bertram Roth, Indianapolis; Charles H. Rushmore, Indianapolis, consultant.

Public Information
Frederic L. Schoen, Fort Wayne, Chairman; William B. Challman, Evansville, Vice-Chairman; William G. Moore, La Porte, Secretary; Louis Blessinger, Corydon; Herman J. Echsner, Columbus; William G. Bannon, Terre Haute; Robert D. Spindler, Shelbyville; Robert W. Harger, Indianapolis; Don W. Boyer, Lebanon; Thomas C. Chael, Munster; Fred C. Poehler, La Fontaine; Louis F. Sandock, South Bend; Loren H. Martin, Indianapolis.

Special Activities
Marvin E. Priddy, Fort Wayne, Chairman; Robert M. Brown, Marion, Vice-Chairman; Norbert M. Welch, Vincennes; Robert O. Zink, Madison; John E. Freed, Jr., Terre Haute; Harold C. Ochsner, Indianapolis; Henry Bibler, Muncie; Clarence G. Kern, Lebanon; Adolph Walker, East Chicago; K. G. Hill, New Castle.

Voluntary Health Agencies
Norman R. Booher, Indianapolis, Chairman; James H. Gosman, Indianapolis, Vice-Chairman; M. O. Scamahorn, Pittsboro, Secretary; Albert Ritz, Evansville; Ed R. Cantwell, Vincennes; T. A. Neathamer, Scottsburg; Harry R. Baxter, Seymour; William G. Bannon, Terre Haute; Wayne Endicott, Greenfield; William A. Karsell, Indianapolis; James S. Fitzpatrick, Portland; Albert E. Applegate, Frankfort; John G. Kolettis, Gary; Lloyd L. Hill, Peru; Richard Willard, Bluffton; Frank McCue, Michigan City.

Future Planning Committee
Earl W. Mericle, Indianapolis, chairman; Maurice E. Glock Fort Wayne; James S. Fitzpatrick, Portland; A. Wayne Ratcliffe, Evansville; Fred S. Carter, LaPorte; William B. Challman, Mount Vernon; James E. Wenger, Nappanee; Charles F. Gillespie, Indianapolis; Leslie M. Baker, Aurora, (Ex-Officio Members)—Patrick J. V. Corcoran, Evansville; G. O. Larson, La Porte; Lowell H. Steen, Whiting; Ralph V. Everly, Indianapolis; Frank B. Ramsey, Indianapolis.

1967-68 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	R. E. Weitzel, Princeton	Fred Smith, Tell City	
2.	Brad Bomba, Bloomington	J. S. Brown, Carlisle	
3.	Daniel H. Cannon, New Albany	Elmer L. Wallace, New Albany	April 2, 1969, New Albany
4.	Bill E. Freeland, Batesville	William J. Warn, Milan	
5.	Jack Somerville, Clinton	Milton Herzberg, Clinton	
6.	Stephen Smith, Knightstown	David Wynegar, Richmond	
7.	John O. Butler, Indianapolis	Donald E. Stephens, Indianapolis	
8.	F. E. Stout, Muncie	Richard N. Philbert, Muncie	June 4, 1969, Muncie
9.	Martin Dickerson, Monticello	M. Ali Jehanyar, Monticello	May 22, 1969, Lafayette
10.	R. J. Doherty, Crown Point	Lambro Dimitroff, Calumet City, Ill.	
11.	John D. Pattison, Marion	Fred Poehler, La Fontaine	Sept., 17, 1969, Marion
12.	Kenneth F. Isenogle, Fort Wayne	John J. Hartman, Angola	May 21, 1969, Fort Wayne
13.	John Kerrigan, Michigan City	John Hildebrand, South Bend	

Dilantin®
(diphenylhydantoin)

PARKE-DAVIS

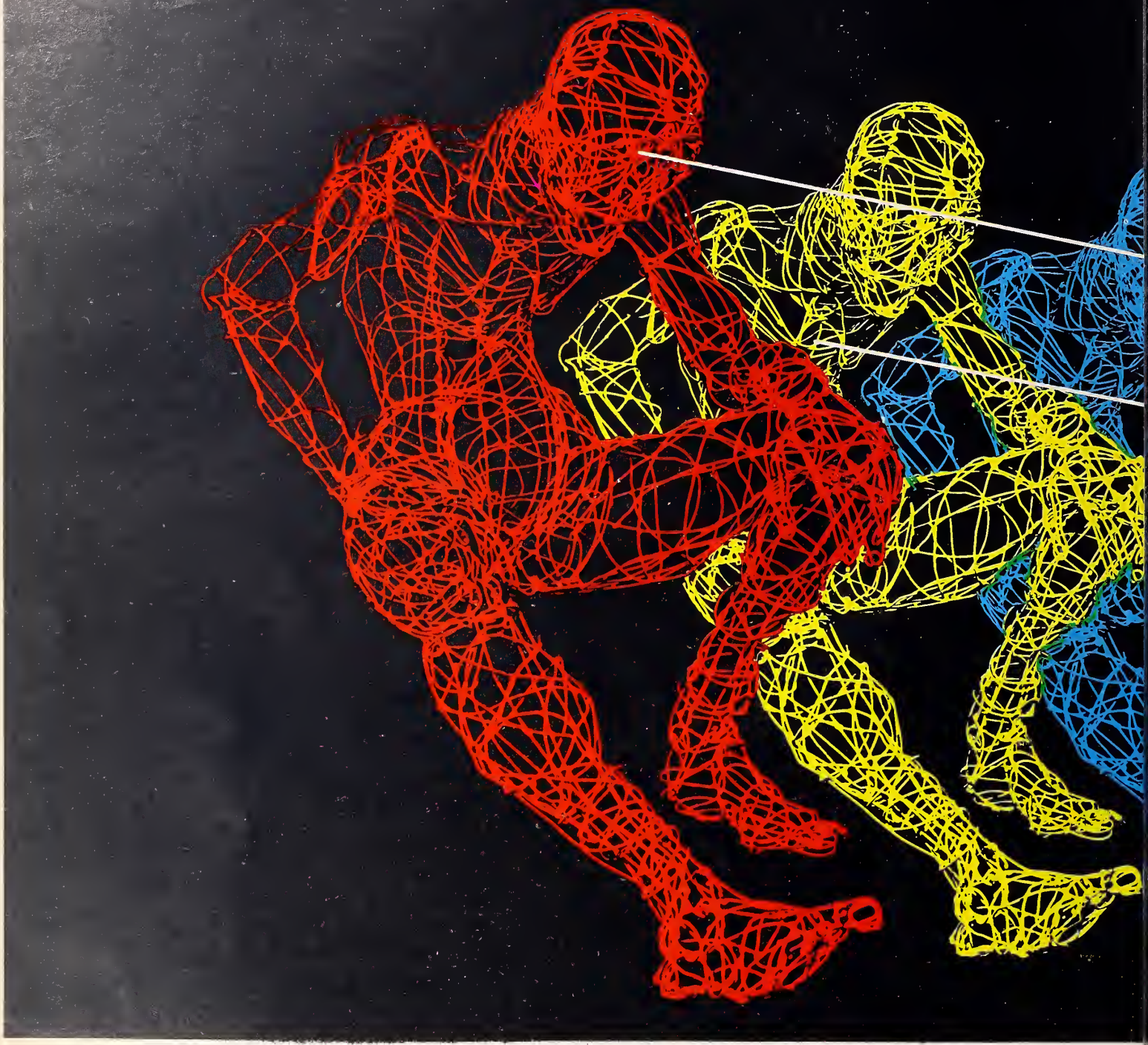
In untold thousands of epileptic patients... Dilantin has been, and continues to be, the bedrock of therapy.

DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anticonvulsant drugs.
PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. ADVERSE REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred.
DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.
Parke, Davis & Company, Detroit, Michigan 48232

The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium.

PARKE-DAVIS 015R67

a comprehensive hematinic



Description: Each Pulvule® contains—

Special Liver-Stomach Concentrate, Lilly (containing Intrinsic Factor)	150	mg.
Cobalamin Concentrate, N.F., equivalent to Cobalamin	7.5	mcg.
(The total vitamin B_{12} activity in the Special Liver-Stomach Concentrate, Lilly, and the Cobalamin Concentrate, N.F., is 15 micrograms.)		
Iron, Elemental (as Ferrous Fumarate)	110	mg.
Ascorbic Acid (Vitamin C)	75	mg.
Folic Acid	1	mg.

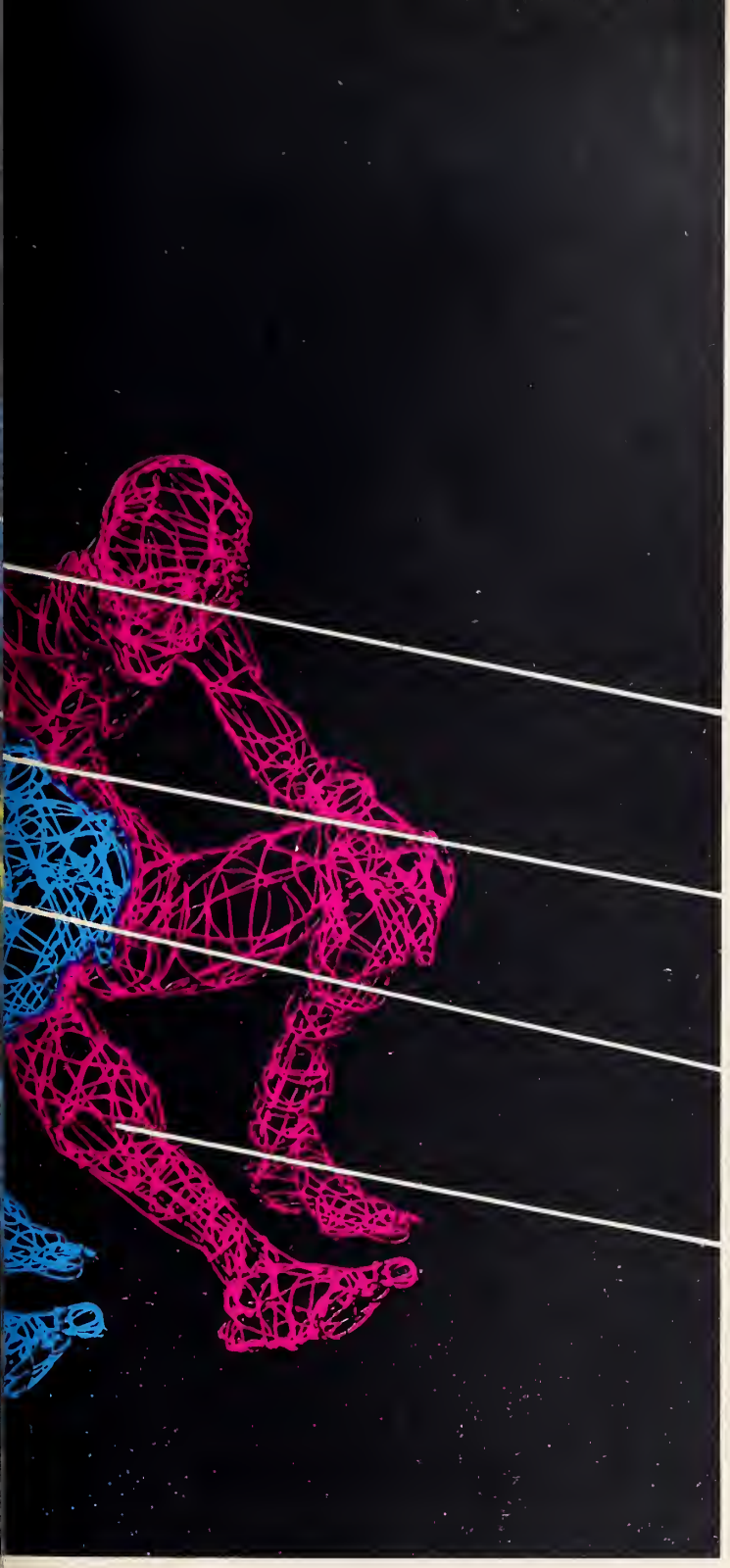
Indications: Trinsicon® (hematinic concentrate with intrinsic factor, Lilly) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia.

Contraindications: Hemochromatosis and hemosiderosis.

Precautions: Anemia is a manifestation that requires appropriat investigation to determine its cause or causes.

In pernicious anemia, the use of folic acid without adequat vitamin B_{12} therapy may result in hematologic remission but neu rological progression. Adequate doses of vitamin B_{12} (parentera or oral with potent intrinsic factor as in Trinsicon® [hematini concentrate with intrinsic factor, Lilly]) usually prevent, halt, c improve the neurological changes.

As with all preparations containing intrinsic factor, resistanc may develop in some cases of pernicious anemia to the potentia tion of absorption of physiological doses of vitamin B_{12}. If resis ance occurs, parenteral therapy, or oral therapy with so-calle massive doses of vitamin B_{12}, may be necessary. No single reg men fits all cases, and the status of the patient observed i follow-up is the final criterion for adequacy of therapy. Periodi



You can treat combined deficiencies with

Trinsicon®

—the multifactor hematinic

Vitamin B_{12} plus intrinsic factor (15 mcg. B_{12} activity)—helps provide adequate levels of this important vitamin.

Folic acid (1 mg.)—treats nutritional macrocytic anemias and/or malabsorption syndromes.

Ascorbic acid (75 mg.)—augments the conversion of folic acid to its active form and helps iron absorption.

Iron (110 mg.)—treats hypochromic anemia.

clinical and laboratory studies are considered essential and are recommended.

Adverse Reactions: In rare instances, iron in therapeutic doses produces gastro-intestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects.

In extremely rare instances, skin rash suggesting allergy has followed oral administration of liver-stomach material. Instances of apparent allergic sensitization have also been reported after oral administration of folic acid.

Dosage: One Pulvule twice a day. (Two Pulvules daily produce a standard response in the average uncomplicated case of pernicious anemia.)

How Supplied: Pulvules Trinsicon® (hematinic concentrate with intrinsic factor, Lilly), in bottles of 60 and 500. [032568]

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206.

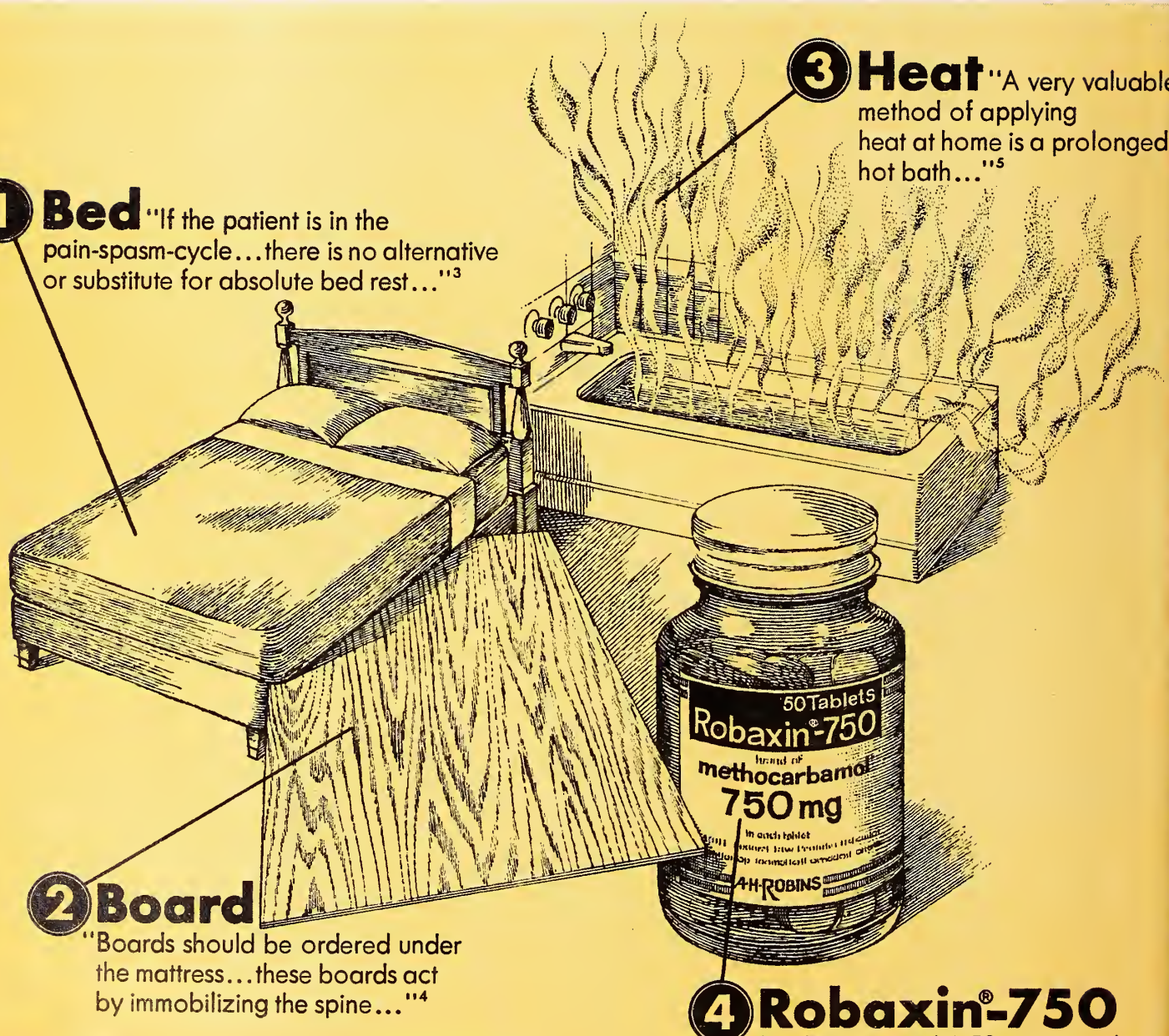
801668

Lilly

LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:



1 Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

2 Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

3 Heat "A very valuable method of applying heat at home is a prolonged hot bath..."[5]

4 Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

Indicated for relief of skeletal muscle spasm. **Contraindicated** in hypersensitive patients. **Side Effects** (lightheadedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently. See product literature for further details. **Also available:** Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.)

References: (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottschalk, L.A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cozen, L.: South Dakota J. Med. 18:26, 1965. (5). Soto-Hall, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

A·H·ROBINS A. H. ROBINS COMPANY RICHMOND, VIRGINIA 23220

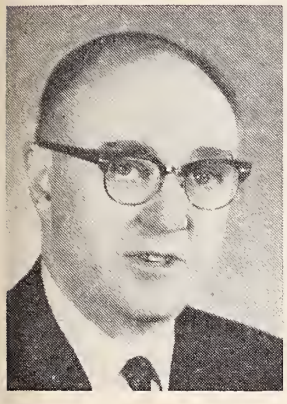
President's Page

PRIORITIES — 1969

This festive season will shortly be succeeded by a period of reappraisal and of resolutions for the New Year.

What is our program for 1969?

1. The biennial session of the Legislature will, in the first 61 days of the year, make some lasting imprints on our personal and professional lives. The full resources of the association will be mobilized to deal with the many known—and the numerous as-yet-unknown—matters on which we may need to advise our legislators. The Commission on Legislation will meet every Wednesday in January and February; the officers and staff will be continually available seven days a week during the session. We will welcome your suggestions and, in turn, we may have to call on you for specific chores.



2. Commissions and committees of ISMA are getting organized and setting up their programs. Please forward your ideas to the headquarters office, or to me, for referral to the proper group. There must be a wealth of constructive projects gestating in the minds of our members. The problem is to induce delivery!

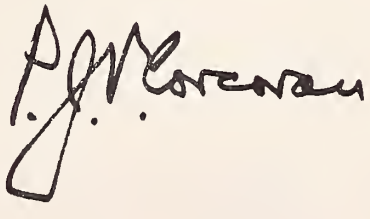
3. Early next year, we shall hold a Conference of Medical Society Officers. It will be devoted primarily to emergency medical care, continuing medical education and to Medicaid, which will probably be adopted in Indiana by then. This meeting of presidents and secretaries of county societies can be fruitful and productive. Every local society will profit by having its officers attend.

4. The annual meeting of ISMA should be the center of a constellation of meetings of all the other medical groups in the state. Use your influence to persuade your own specialty or practice society to schedule its annual meeting in conjunction with ISMA.

5. Decisions are to be made regarding medical education—a second medical school, the forms of postgraduate training, recruitment of students, the role and training of paramedical workers, and maintaining rapport with medical students.

6. Many problems of medical practice and health services—some current, some incipient—face us: emergency care, automation, computers, the growing paper load, increasing third party involvement, new aspects of moral issues. We must anticipate, understand, cope with, or solve them as well as we can.

The New Year brings new challenges, new options, new hope!



Finally...a salicylate superior to aspirin?

Not at all, Doctor...but

magan®

(magnesium salicylate, W-T)

should be considered for your arthritic and rheumatic patients who cannot tolerate aspirin.

Surveys * made in 1966 and 1967 among private practice physicians showed an incidence of intolerance to aspirin ranging from 3-85%. The majority of physicians surveyed reported an intolerance in 10-30% of their patients.

How does this compare with your experience?

*by two independent national research organizations

WARREN-TEED PHARMACEUTICALS INCORPORATED
COLUMBUS, OHIO 43215
SUBSIDIARY OF **ROHM AND HAAS COMPANY**

10-30%

Don't use Magan on all your patients–

consider Magan for those patients who cannot take aspirin because of gastric discomfort

Private Practice Physicians tried Magan on almost 700 patients whom they judged intolerant to aspirin and other salicylates.

The majority of these patients could take Magan and obtain the benefit of salicylate therapy.

magan® **an alternate salicylate**

(magnesium salicylate, W-T)

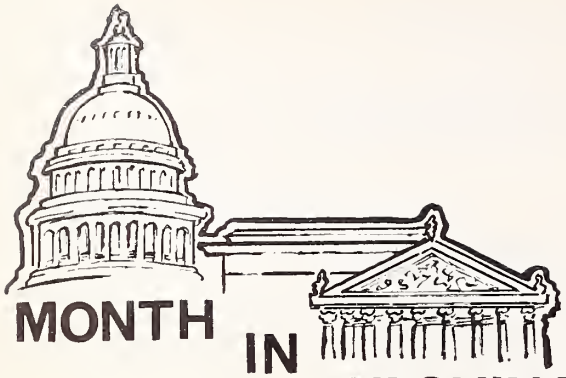
May be tolerated by some persons intolerant to aspirin by reason of gastrointestinal irritation.

Magan is a new salicylate product from Warren-Teed.

A single chemical entity . . . no coating, no buffering, sodium free and non-acetylated.

Composition: Each orange colored tablet contains 5 grains (approx. 325 mg) of magnesium salicylate.

Dosage: 1 or 2 tablets every 4 hours with a full glass of water.



MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

WASHINGTON, D.C.—Three-fourths of the medicare Part B carriers now are using individual physician fee profiles in determining reasonable charges.

THE Social Security Administration said that these carriers, a total of 36, collectively process 80% of the medicare bills submitted by physicians. Prevailing fees continue as a major factor in the reasonable charges determined by the carriers.

THE REMAINING 14 carriers which have not yet fully developed the individual physician fee profiles, or the computer capacity for using them, are employing other interim techniques. Some use, in addition to prevailing fees, fee schedules; others use relative value scales, or similar techniques, in determining reasonable charges.

THE MEDICARE law calls for individual determinations by the carrier which take into account the customary charges of the physician and the prevailing charges in the locality for similar services. In addition, carriers must assure that the charges determined to be reasonable for medicare beneficiaries are not higher than the charges for comparable services under comparable circumstances to their own policyholders and subscribers, according to the SSA.

PAYMENT is to be made on the basis of the lowest of those three criteria, or the physician's actual charge, if that is still lower, the SSA said.

"MAKING a reasonable charge determination involves checking each bill against compiled data on the individual physician's customary charges for similar services and the prevailing level of charges for such services in the locality in which the physician practices," the SSA said.

"THE DEVELOPMENT of physician fee profiles," according to Thomas M. Tierney, medicare's director, "present a unique challenge to both the SSA and the contracting carriers. At the time of medicare's enactment, there was no industry-wide pattern in the health insurance field on the approach to reasonable charge determination.

"THERE IS evidence now that the successful application of the guidelines interpreting the medicare reasonable charge provisions, including the required development and use of individual physician fee profiles, is leading to a more systematized and consistent approach to the payment of physicians' bills in the health insurance field generally."

THE MEDICARE hospital deductible will be increased from $40 to $44 January

1, 1969. The law specifies that if an annual review shows that hospital costs have changed significantly, the hospital deductible amount must be adjusted for the following year. Necessary increases in the deductible amount are to be made in $4 steps to avoid small annual changes.

PHYSICIAN SHORTAGE LISTED AS CAUSE FOR FEE HIKES

THE SHORTAGE of physicians, particularly general practitioners was cited in a government report as a factor in the increase in physicians' fees since World War II.

THE BUREAU of Labor Statistics (BLS) reported that charges for medical care, including hospitalization, had risen at an annual rate of 3.9% since World War II while prices of all consumer items combined advanced at a rate of 2.6% per year. The bureau said that medical care prices had risen at a faster rate in recent years, 6.6% in 1966 and 6.4% in 1967.

THE REPORT SAID that physicians' fees, while not advancing as rapidly as hospital charges, had more than doubled in the past 10 years. Hospital charges more than quadrupled.

"THE RISE in physicians' fees during the 1946-67 period is partially due to the general rise in price levels and to the physicians' need for increased income to cover his personal and business costs," the report said.

"THIS IS especially true for the past two years. Doctors have tended to attribute their higher fees in recent years to the general economic conditions and the higher cost of doing business. Nevertheless, some charges clearly reflect the shortage of doctors. With an overload of patients, physicians in some cases have tried to discourage the practice of making house calls by raising the rate for such a service to a level that few patients are willing to pay. The postwar emphasis on medical specialists has also helped to boost physicians' fees since general practitioners have become scarce and specialists, with their extra training, are able to command higher fees."

THE NUMBER OF G.P.'s declined from 73,593 in 1963 to 68,920 in 1967 while the number of physicians in all categories was increasing from 276,475 to 308,475.

THE BLS conceded that its reports on health care costs do not give adequate consideration to improvements in the quality of medical care as reflected in longer life spans, improved and more efficient techniques for treatment, shorter hospital stays, etc.

"IT IS obvious that there are many problems of definition and measurement to be solved before any progress can be made in introducing appropriate methods of measuring medical care price changes in a more meaningful way," the report said.

MEDICAL CARE FOR THE POOR STUDIED

TWO OTHER federal developments dealt with medical care for the poor. The Board of Medicine of the National Academy of Sciences announced start of a comprehensive, two-year study titled "Health and the Poor." A joint state-federal task force reported on its study of costs for medical and public assistance programs.

THE BOARD OF MEDICINE named a special panel for its study which will cover: the quantity and quality of medical care the poor now receive;

Continued

existing federal programs, such as medicaid, anti-poverty projects, maternal and child health programs, and community immunization programs; future needs and possible programs; and the economics of medical care for the poor.

RECOMMENDATIONS of the joint task force to the Department of Health, Education and Welfare included:

—States should draw samples to produce information on the current utilization of each of the medical care services offered, and their costs. The sample should provide data on how much of these costs are borne by the medical assistance program, and the amount that comes from other sources.

TOUGHER PENALTIES FOR DRUG TRAFFIC

PRESIDENT JOHNSON signed into law a bill providing for tougher penalties for illegal traffic in amphetamines and barbiturates. LSD also is covered specifically.

THE NEW LAW makes illegal possession, manufacture or disposal of the drugs a misdemeanor carrying maximum penalties ranging from imprisonment of one year and a fine of $1,000 to imprisonment of 15 years and a fine of $20,000. Leniency is authorized for first offenders.

JOHNSON PRAISED the law as a measure that will "strengthen the hands of our police and give our families protection." He said it should "put the drug peddler in jail." But, he added, the active support of all Americans—boths adults and young—is needed.

NIXON'S POSITION ON HEALTH INSURANCE, CONTROL OF FEES

RICHARD M. NIXON will take over as President pledged to oppose national compulsory health insurance and federal control of physicians' fees. Highlights of his position on health care issues:

FEDERAL ROLE IN MEDICINE

The role of the federal government in medicine should be supportive, never dominating. It should serve as a catalyst and supplement private efforts only as needed.

MEDICARE

Although the program has been plagued by financial and administrative problems, it offers good potential if wisely administered.

Medicare must provide needed services at the lowest possible cost. The program could be endangered by a continuing escalation of costs.

More effort is needed to reduce dependence on costly hospitalization through better use of extended care facilities and increased use of outpatient care. Also needed is a reexamination of reimbursement formulas and experimentation with financial incentives to assure that the program encourages efficiency at all levels.

MEDICAID

I favor the basic philosophy of medicaid—that of helping

medical indigents who need aid to meet medical expenses. Unfortunately, the program has fallen short of its expectations . . . .
What is needed is a careful reassessment of medicaid, especially at the local level, with full professional guidance and emphasis on advice from physicians. There also is a need for simplification of literature and application forms.

NATIONAL COMPULSORY HEALTH INSURANCE

I oppose a national compulsory health insurance program because I do not want to lower the quality of medical care in the United States. Also, new health programs should be geared only to persons in need . . . .

I want to see that every individual who needs medical care is able to get it. But I want it to be good medical care. That's why I want to keep the doctors free from government control as much as possible and oppose extension to a national compulsory health insurance program for everyone.

COMPULSORY AREAWIDE HEALTH PLANNING

I oppose compulsory areawide health planning. We can't assure communities better health planning just by making such groups compulsory. Areawide planning should be left to state and local determination.

FEDERAL CONTROL OF PHYSICIANS' FEES

I oppose federal control of physicians' fees. Our system is an open, competitive market, assuring an individual the prerogative of setting a value on the services he performs. I would be as opposed to infringing on this right by regulation of physicians' fees as I would be to regulating fees charged by the members of any other profession.

DEPARTMENT OF HEALTH

As President, I intend to establish a Commission on Government Reorganization to study thoroughly ways of increasing efficiency in government organization as well as making it more responsive to the people.

MENTAL HEALTH

We must develop new methods of treating the mentally ill . . . .

TAX DEDUCTIONS FOR THE AGED

The 100% income tax deduction for non-reimbursable drug and medical expenses of those over 65 should be restored.

PREVENTIVE MEDICINE

Preventive medicine is, in my judgment, both an opportunity and a major challenge to medicine.
Automated mass screening programs would seem to have great possibilities even though they are generally still in their infancy and therefore cannot yet be gauged concerning their

Continued

Continued

effectiveness in preventing chronic illness and reducing deaths. Information about these programs is still inadequate to warrant a broad federal program.

HILL-BURTON ACT

As demand for hospital facilities increases, additional funds under the Hill-Burton Act for construction and modernization of such facilities will be required to supplement state and local efforts.
To assure the most efficient use and distribution of Hill-Burton funds, a proposal for bloc grants in this area should be considered.

ABORTION LAWS

Nothing should be done on the federal level. The abortion laws should be considered by each state, and should be acted upon by each state, depending upon the opinion in that state . . . .
I do not think that a nationally-imposed law would be one which would be accepted in many parts of the country, and only when a state—a majority of people of the state—reach a conclusion that they want that kind of legislation, as they did in Colorado and as they may in the state of New York, should such a law be passed or considered. ◀

About Our Cover

A candle's but a little thing—
It starts with just a bit of string.
Yet clipped and dipped with patient hand,
It gathers wax upon the strand.
Until, complete and snowy white,
It gives at last a lovely light.

Life seems so like that bit of string—
Each deed we do, a simple thing.
Yet day by day, if on life's strand,
We work with patient heart and hand,
It gathers joy, makes dark days bright,
And gives at last a lovely light.

Author unknown

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.

The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.

A realistic approach to pain relief

Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.

Louie lost weeks with acute shoulder bursitis. That's a lo
of pain, stiffness and tenderness...and also a lot of fisl
It might have been different with **Butazolidin® alka**

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

If it doesn't work in a week, forget

But please don't forget this:

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alka formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Painful Shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

(B) 46-070-8

For complete details,
please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Butazolidin® alka Geigy

Capsules
100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

BU-6210

When it's more than a bad cold

your patient can feel better while he's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

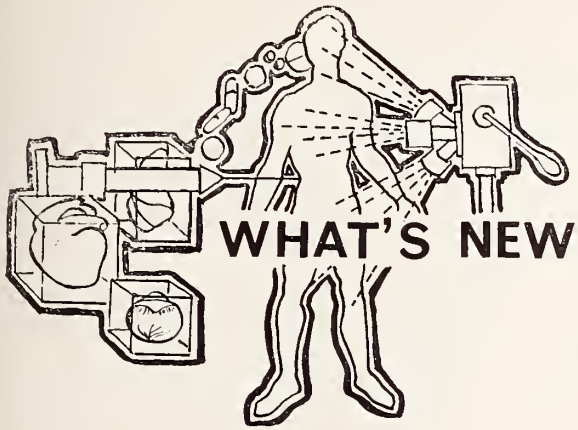
Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

350-8



Eaton Laboratories is adopting an identification code which will appear on all their tablets, suppositories and capsules in addition to the name "Eaton" written in script. All tablets intended for use only as physicians' samples will bear the word sample. The key to the new code will be announced in inserts, by special literature and by advertising.

* * *

Schering is introducing a new low-dosage strength of Etrafon. Called Etrafon 2-10, it is a combination of Trilafon (perphenazine), a tranquilizer, and amitriptyline hydrochloride, an antidepressant. Etrafon 2-10 with previously marketed Etrafon, Etrafon-A and Etrafon Forte provides four dosage ratios to care for patients with varying degrees of depression and anxiety.

* * *

Sorbitrate® (Atlas isosorbide dinitrate) has been approved as a new drug by FDA. It is useful for the prevention and treatment of angina pectoris. Stuart will market it in four dosage forms: 5 and 10 mg. oral tablets, 5 mg. sublingual tablets, and 10 mg. oral tablets with 15 mg. of phenobarbital. The sublingual tablets have an onset of action of two to five minutes and a duration of effect of one to two hours.

* * *

Lederle is introducing a new oral antituberculosis drug, Myambutol ethambutol. The agent has been found to be active against strains of the bacillus resistant to other drugs. The FDA has just approved it for marketing. The advantages mentioned are: specific high activity against the tubercle bacillus, ease of administration, low incidence of side reactions, lack of cross-resistance with other antituberculosis agents, slow emergence of resistant strains and good patient acceptance.

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments, and surgical appliances and book publishers. Each item is published as news and does not necessarily constitute an indorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

I'll admit he has a highly unusual bedside manner!

ANNUAL CLINICAL CONFERENCE

Chicago Medical Society

March 2, 3, 4 and 5, 1969

Palmer House, Chicago

Lectures

Medical Color Telecasts

Trauma Conference

Instructional Courses

The CHICAGO MEDICAL SOCIETY ANNUAL CLINICAL CONFERENCE should be a MUST on the calendar of every physician.

Plan now to attend and make your reservation at the Palmer House.

Letters to the editor

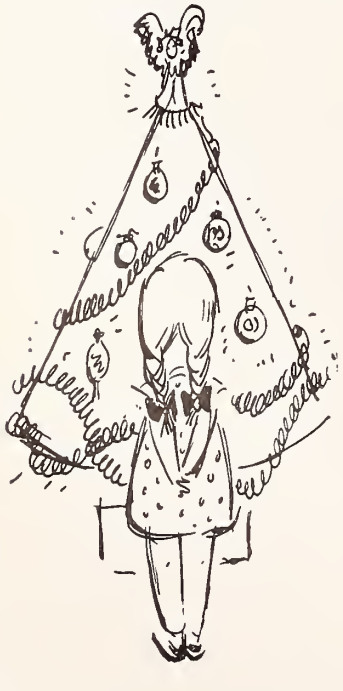
To the Editor:

The following is my personal review and evaluation of the senior medical student preceptorship program:

I have just completed spending a six-week training period with Dr. James Black, a nine-year general practitioner in the office of Black, Walker, and Baker in Brownsburg, Indiana. Dr. Black has just recently moved into a modern office with nine examining rooms, a physical therapy room, an x-ray room and a minor surgery room. His hospital care is practiced in the modern Hendricks County Hospital, Danville, Indiana.

Although, at the present time, I do not intend on going into general practice, I feel that I have gained a great deal frrom the training I received in working with a family physician. Variety must certainly be the motto of the general practitioner. While on my preceptorship I saw and helped to treat persons with many complaints and illnesses.

A few examples might be a young woman in the hospital for premature labor who suffered a drug reaction to Sparine and went into shock; a dyspneic elderly man who caught a cold but who in three days' treatment with digitoxin and diuretics became asymptomatic; a three-year-old boy who drank a bottle of Drano and suffered pharyngoesophageal burns; an elderly female diabetic in Ketoacidosis with constantly fluctuating blood sugars; a despondent and depressed middle-aged female who thought of taking her life when her husband threatened to leave her; a one-year-old baby with meningococcal meningitis; a football player with hemarthrosis that had to be aspirated; a one-year-old who lacerated her tongue when she fell onto a sidewalk; a senior high school student with a relapse after apparent remission of infectious hepatitis; a seven-year-old with persistent asthma; a seventeen-year-old mother of one month with recurrent attacks of cholecystitis; multiple teenage boys seeking athletic physicals; a middle-aged laborer with bilateral direct inguinal hernias; an elderly male with too-many-pack years who was deteriorating rapidly in the final stages of unresectable carcinoma of the lungs; the many children and young adults with upper respiratory infections, otitis media and tonsillitis; the blue bloaters who won't stop smoking but yet return for help when they become dyspneic; the mothers in waiting returning for their prenatal check-ups; the wise and cautious women who get their yearly Pap smear; a middle-aged, jovial lady with a three plus cystocele and rectocele who developed hemorrhagic cystitis during her postoperative course; a seven-year-old with a chronic history of tonsillitis who underwent T and A surgery; a truck driver with low back strain; a postmenopausal female with lumbar osteoporosis; the new mother back for her six weeks pelvic check-up; a stubborn diabetic with a possible myocardial infarction who wouldn't stay on bed rest; a 97-pound sallow male with a relapse of regional enteritis; and a 48-year-old male admitted to the coronary care unit who developed episodes of ventricular tachycardia that were quickly treated with lidocaine.



The list is longer with routine vaccinations, DPT's, lacerations, hypertensive check-ups, stubbed toes, jammed fingers, ingrown toenails, poison ivy, dermatitis, diaper rash, hyperventilation syndrome, jittery nerves, anxious mothers, depressed wives and crying infants. Variety and quantity are certainly linked with the term "general practice."

This experience working with a family physician was my truly first experience with returning patients who could be followed from week to week. This type of practice also reinforced the concept of "treat the patient and not just the disease." People bring their down-to-earth problems to their family doctors, whether it be family planning, dyspareunia or halitosis.

I am certainly grateful for having had the opportunity to be able to see good "common sense" medicine in action. I feel that this training program should be a must for every medical student. Although I may not become a "GP", my respect for them has certainly grown and I feel they are the cornerstones of American medicine.

Respectfully,

(s) .....

Donald L. Wakefield
Senior Medical Student
3261 Tara Ct. E., Apt. D
Indianapolis 46224

If you live in Indiana you can earn

6%

ANNUAL RATE

in 3 to 9 months

with new Associates Investment Notes

Invest $100 minimum

up to $10,000

1. Associates Investment Notes pay a big 6% annual rate. This exceptionally high rate of interest is available to investors of both large and small sums. When a note matures, the money may be re-invested.

2. Associates Investment Notes are an exceptionally flexible form of investment. The money you invest need not be tied-up for a long period of time. You can invest for as brief a period as 3 months, if you wish.

3. Associates Investment Notes are available throughout Indiana. Notes may be purchased at any Associates office in Indiana. This includes offices of Associates Finance Company, Associates Discount Corporation, Associates First Finance Corporation or Associates First Discount Corporation.

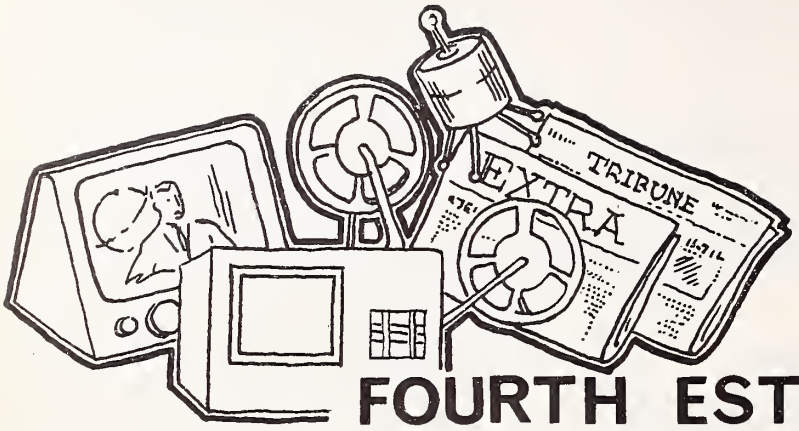
4. Associates Investment Notes are available to any Indiana resident or Indiana businesses, churches, clubs or other organizations. You must be an Indiana resident in order to be the registered holder of an Associates Investment Note.

5. Associates Investment Notes are backed by Associates Investment Company, with over one and one-half billion dollars in gross assets and over 200 million dollars of net worth, plus a half-century of financial experience. For more information call or visit your nearest Associates Office listed in the telephone directory.

THE ASSOCIATES 50 YEARS 1918-1968

ASSOCIATES INVESTMENT COMPANY

1700 Mishawaka Avenue
South Bend, Indiana 46624



FOURTH ESTATE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

The Editor's Notebook

Citizen Dr. Paul D. Crimm's Career

By ED KLINGLER

It's hardly likely the community ever will have another citizen quite like Dr. Paul D. Crimm.

There aren't many like him in the medical profession, either.

He would tangle with anyone, anytime in defense of his viewpoint. From time to time he has been referred to as "controversial," but that same term could be used to describe almost anyone with courage enough to fly in the face of popular opinion.

The trouble with Dr. Crimm, he had a most annoying habit of being right, and some people just can't stand being found wrong.

Dr. Crimm won most of the many battles in which he has engaged, but as he approaches the end of his public career about Sept. 1 when he retires as medical director at Boehne Hospital, the fact remains that in spite of the battles won, he lost the war.

For the last 25 years he has pleaded, wheedled, argued and threatened in his attempts to convert Boehne from its primary function of treating tuberculosis into a county-owned general hospital.

Aside from saving lives, this project became the principle endeavor of his career in Evansville, which began in 1929.

It's entirely possible that before too long a great many people will wish he'd been successful. The fact is, his defeat may be considerably more crushing than appears on the surface.

As recently as 15 years ago, what Dr. Crimm proposed to convert Boehne Hospital would have cost little more than $2 million, because he proposed a minimum beginning.

Today it would cost more than twice that much.

Dr. Crimm couldn't even get adequate funds to maintain Boehne as a tuberculosis treatment center. It lost its accreditation, patients have been moved elsewhere, and today it functions mainly as a nursing home for indigents and older people.

From the very beginning of his campaign to make Boehne into a general hospital, he maintained the same objective as to its function. He wanted an institution that would care for convalescents, the indigent sick, and the elderly. He argued eloquently that a publicly owned institution could do it at less cost than a private institution, and that the problem of this type of care would become increasingly costly to taxpayers as time went on and the number of patients increased.

In retaliation, those who opposed the plan were unsparing in their criticism of Dr. Crimm. He was an empire builder, he wanted to create a lifetime job of importance to himself, he wanted to practice socialized medicine.

It was unjust. He already had the job, and he was, and is, an outspoken opponent of anything resembling socialized medicine. As a matter of record, as president of the Vanderburgh County Medical Society and Indiana Medical Society he warned repeatedly that socialized medicine was on the way.

It didn't endear him to a great many of his fellow physicians when he warned that if they wished to maintain their professional independence, they would have to face the public with clean hands. Over and over, privately and publicly, he warned physicians to be scrupulously ethical, and to come out of their offices and be community leaders.

There was one group of people who did not then, or at any time since, find anything to criticize about Dr. Crimm. This was the tubercular patients who had been under his care.

While Dr. Crimm could be blunt with anyone else, he always was sympathetic and understanding with his patients.

He has been a valuable citizen in this community. As superintendent of Boehne Hospital for years, and later as medical director, he performed with skill and efficiency. As a leader in public health affairs he could, and did, speak with authority and good sense.

He has earned the rest he hopes to get.—*The Evansville Press,* Aug. 17, 1968.

Continued

Escape to the warm sunshine of South America! Our South American Adventure is a once in a lifetime chance to make your vacation dollars go farther than you believed possible . . . all the way to three of South America's most exciting capitals — QUITO . . . BUENOS AIRES . . . RIO DE JANEIRO.

It's your vacation — plan each day yourself! Choose from optional daily sightseeing tours, shop, bask in the sun, golf, nightclub or relax whenever you please for two fun filled weeks!

It's a completely new way to travel to South America — nonregimented!

Fort Wayne Medical Society
Travel Seminar for All Members and Family of
Indiana State Medical Association

SOUTH AMERICAN ADVENTURE

$798

Complete

Departing Indianapolis
February 19, 1969

Send to: RETURN THIS COUPON NOW!

Fort Wayne Medical Society
212 Medical Center Building
Fort Wayne, Indiana 46802

Enclosed is my check for $_____ ($100 per person) as deposit. Final payment is due 60 days before departure. Make check payable to: Manchester Bank — South American Adventure Trust Account.

NAME_____ PHONE

ADDRESS_____
CITY STATE ZIP

MAKE YOU RESERVATIONS NOW — SPACE STRICTLY LIMITED!

The Nation's Health

The medical profession is deeply involved in seeking answers to the broad social and economic problems with which the nation must deal. Passing and appropriating tax money does not of itself solve any problem. Nowhere is this more true than in the field of medicine, since government simply does not have the professional personnel to provide adequate medical service.

Looking back over the past year, Milford O. Rouse, immediate past president of the American Medical Association, has observed that the medical profession has continued to work with Congress in improving legislative proposals in the medical field and to implement the programs, including medicare, which have already become law. The ability and willingness of American medicine to work alongside of government has been demonstrated.

Commenting on the future, Dr. Rouse noted, ". . . The social planners of the federal government may 'legislate' into being one welfare medical program after another, by money appropriations, but it cannot 'legislate' the success of a single one of them. That depends upon the active support and collaboration of the medical profession . . . . Therefore, it is highly in order for the federal government to join with medicine in a sincere effort to improve definitely and continually the several systems of provision for health care in our great society."

Carrying this idea forward at a meeting of the American Medical Association, proposals were made for a largely private system of health insurance which would pay for medical care for everyone under age 65 — all those not covered by medicare.

Private initiative is moving to find ways to meet the health care costs of the present and future, while preserving the incentives, individuality, high quality and progress that have characterized the development of medicine in the United States. Expansion of the principle of tax supported free health care for all, regardless of need, with its regimentation and mediocrity would inevitably destroy these values and very likely bankrupt the nation's taxpapers as well.—*Franklin Star*, Sept. 5, 1968.

Case for a Medical School

A new Indiana General Assembly will be elected in less than two months and will go to work some two months after that. Among the pressing issues the lawmakers will find waiting for them is their state's need for a second medical school.

They will find that need greater than it was two years ago, when the 1967 Assembly agreed almost without dissent that a new medical school was necessary, and disagreed only over its location.

There has been some improvement in the intervening period in the number of Indiana-trained doctors staying in their home state to practice, but the improvement is pitifully short of meeting Indiana's crying need for new doctors. Nor will such marginal changes in the medical manpower picture come anywhere near solving the problem in the future.

Indiana needs a new medical school. Its lone school, Indiana University School of Medicine at Indianapolis, is the country's largest medical education complex. Making it even larger would be an inadequate response to Indiana's physician shortage.

The Assembly must authorize a second medical education complex, to be located where logic and common sense dictate.

The new school should not be close to the centrally-located I.U. School of Medicine, but in one of the state's other major population centers. We think North Central Indiana clearly offers the most fertile ground for a new medical school.

This end of the state has the population needed to support a medical center. It is a growing population, part of the Milwaukee-to-Cleveland "megalopolis."

North Central Indiana has a wealth of institutions of higher education capable of feeding well-grounded medical students into a new medical school. It is unquestionably the most educationally-oriented region of Indiana.

What this area needs more than anything else as the 1969 Assembly approaches is a united stand on the virtues of this area as a medical school location.

We hope would-be members of the Assembly from Michigan City to Ligonier, from Elkhart to Peru will realize the need for united action if Indiana's new medical school is to be placed in our region — where it should be placed.

They can be sure their counterparts in competing regions will put up a solid front.—*South Bend Tribune*, Sept. 9, 1968.

The Myers Building

A well-earned honor has come to Dr. Charles W. Myers.

The great $12 million, seven-story addition to General Hospital is now officially the Dr. Charles W. Myers Building. This must be a source of satisfaction to a man who has spent most of his life in public service and who superintended the hospital in

the trying depression days when doctors, equipment and funds were in short supply.

Dr. Myers' career was closely linked with the institution, then known as City Hospital, of which he was superintendent for 21 years. He was dedicated to his job, so much so that he lived on the hospital premises. There were times, when other doctors were unavailable, that he performed emergency operations.

Dr. Myers began his medical career in the Army Medical Corps. He was decorated three times in World War I for bravery in evacuating wounded soldiers. After the war he was with the old Veterans Bureau and later became superintendent of the hospital, retiring in 1952.

During his years as superintendent, Dr. Myers saw problems that arose when a hospital becomes involved in the politics of city government. He became active in helping create the Board of Health and Hospitals, an autonomous agency in charge of hospital and health services. He served on the board 16 years, retiring in June of this year.

Dr. Myers gave wholeheartedly of his time and effort to his public duties, and at the same time took part in a host of civic activities. Now 78, he is enjoying a merited rest. His many friends will rejoice that the great new addition to General Hospital will stand as his memorial.—*The Indianapolis News*, Sept. 12, 1968.

Feminine Horizon

By HORTENSE MYERS

Rocking chairs have made such a strong comeback as an article of furniture in American homes that the nation's largest manufacturer of them cannot fill any more orders until next February.

Homemakers who now often have rocking chairs in their living rooms, kitchens and bedrooms are not just staging a return to an old-fashioned era. They have therapy in mind.

Just ask Dr. Carl D. Martz, an Indianapolis orthopedic specialist, who is the author of an article [which ran in the *ISMA Journal*] about the medical value of rocking chairs.

"I am very serious about it," Martz said. "It is extremely rare for a habitual rocker to have swollen feet and legs and this undoubtedly is one of the greatest benefits to the aged."

But he said it has value to younger people also and rocking in a chair "is a very gentle, easy way" to get them to take types of exercise needed in low back treatments.

Roy Fenn, whose family owns a chair manufacturing company in Tell City, once tried to get a rocking wheel chair developed in line with Martz's philosophy about therapy, but failed to find sufficient interest. However, Martz pointed out that hospitals and nursing homes now often have the regular home-type rockers.

The 74-year-old Fenn, whose company is billed as the largest manufacturer of rocking chairs in the United States, said "I made a statement some time ago that the increase in rocking chairs was 10% a year for the last 10 years, but now we get more orders than we can fill. We can't fill any more orders until February."

Fenn and Martz both are rocking chair rockers.

"Besides increasing the blood circulation, it decreases the tension," Fenn testified.

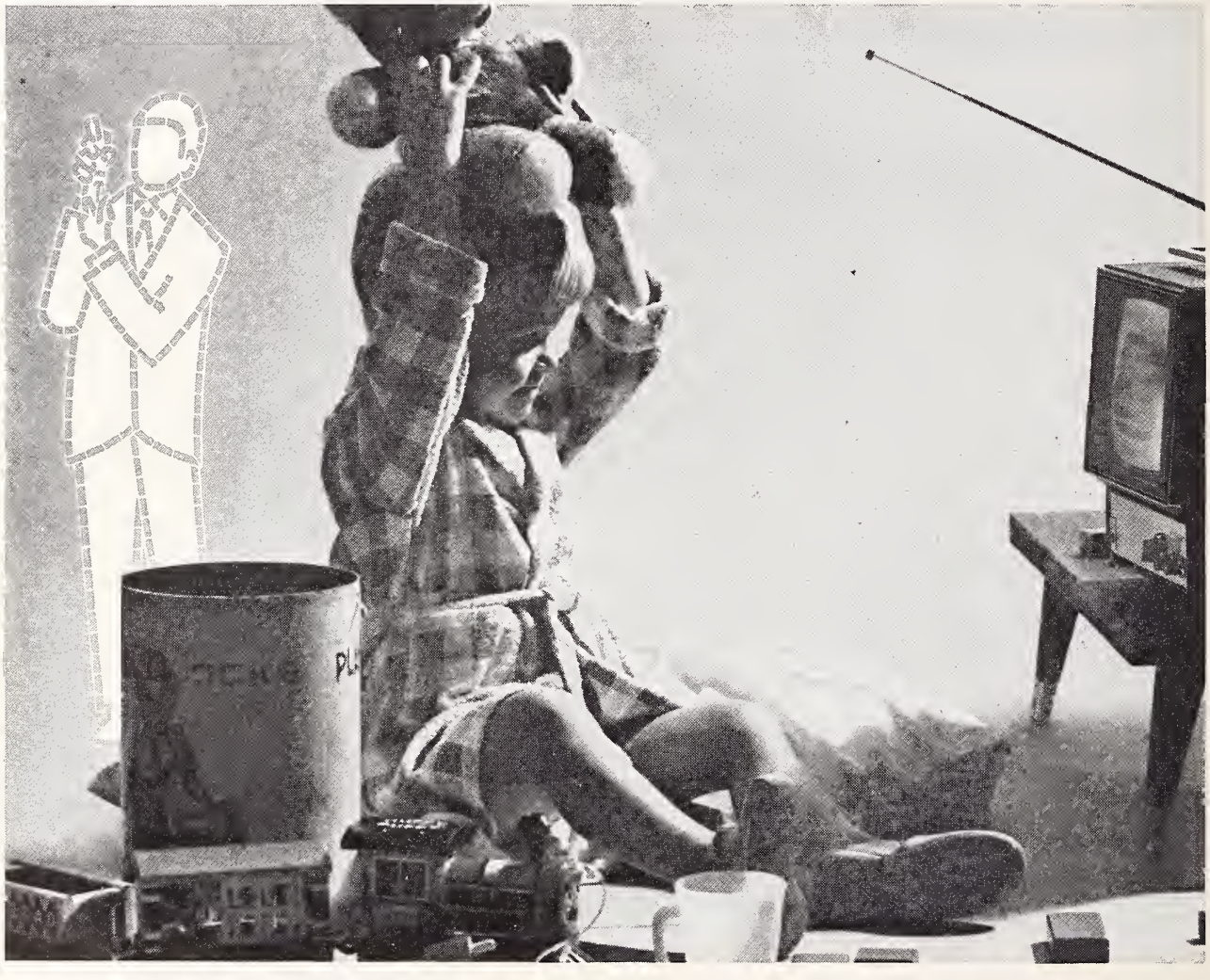
The 54-year-old Martz said that "perhaps the basic benefit of the rocker is that of gently stimulating muscle contraction, thereby improving peripheral circulation." He said the energy required to rock "is about one-half that of walking or cycling and less than one-third that of horseback riding."

"Yet because of the longer duration, the total muscular effort is greater and better tolerated by the aged, infirm or convalescent," he added.

"Benefits to joints from rocking chairs are well recognized and are more and more a part of orthopedic rehabilitation programs. The patient with knitting bones, stiffened joints, or weakened muscles derives welcome relief to discomfort, increasing range of motion and improving muscle function from the gentle effects of rocking," Martz said.

Martz, a graduate of DePauw University and Indiana University Medical School, and a professor of orthopedic surgery at the IU school, also sees sedative value in rocking. In his article, he concludes that in a "troubled world which clamors for sedation, complains of stiffened joints and sagging muscles, demands pain relief, yearns for physical fitness and yet needs serenity, security, and opportunity for contemplation" both young and old can benefit from sitting and rocking.—*Rensselaer Republican*, Oct. 14, 1968. ◄

It's almost as if you were there to give an injection of penicillin



V-Cillin K®, Pediatric dependable oral penicillin therapy

Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567A] 800198

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206

Lilly

The Journal
of the INDIANA STATE MEDICAL ASSOCIATION
Supervised by THE COUNCIL
Volume 61 — December 1968 — Number 12

The advent of supersonic air transports brings with it a new set of problems—greater speeds and acceleration, higher altitudes and exposure to irradiation.

Commercial Supersonic Transportation And The Patient

ROBERT B. STONEHILL, M.D.*
RAYMOND H. MURRAY, M.D.**
Indianapolis

FROM July, 1964, to July, 1965, over 84.5 million passengers were carried by scheduled airlines in the United States.[1] It has been estimated that three percent of airline passengers are ambulatory patients.[2] This means that over 2.5 million ambulatory patients were flying during that period of time. A practical plan for evaluating the ability of the patient to utilize subsonic air travel has been previously reported.[3] With the advent of commercial supersonic air transport (SST), physicians must be prepared to evaluate a patient's ability to use this attractive means of transportation with its attendant special medical problems. Certain physiologic criteria are already apparent which lend themselves to consideration with respect to the ambulatory patient. Special considerations for SST over and above those of today's subsonic aircraft are: speed and acceleration, altitude and irradiation.

The speed of sound varies according to the altitude from 600 to 700 mph. This speed is called Mach 1. Currently aircraft are being developed with Mach 2 and Mach 3 capabilities. Acceleration is a charge in speed such as occurs during take-off or landing. The accelerative forces of the Concord aircraft (Mach 2) are expected to resemble those of the current subsonic jets now in service.[4] However, because of the greater speed to be attained, there will be a longer period of acceleration and thus a longer "seat belt time" where movement around the cabin will be restricted.

With greater speeds the external surfaces of the planes will develop greater heat due to the frictional effect of the atmosphere. To obviate this problem SST's will travel at higher and more rarified atmospheres. Mach 3 aircraft will fly as high as 75,000 feet,[5] and Mach 2 aircraft as high as 65,000 feet.[5] Pressurization of the atmosphere within the cabin in both types of planes will result in a maximum cabin altitude equivalent to 6,000 feet.[5,6] Pressurization will be assured by advanced engineering design and new construction materials, for at the extreme altitudes through which these planes fly, depressurization would be disasterous. At these heights, protection afforded by oxygen masks of the type which can be donned by passengers will be inadequate.

Irradiation Exposure

At altitudes over 55,000 feet, the filtering effect of the atmosphere affords little protection from irradiation. Two types of irradiation penetrate from space, cosmic and solar flare irradiation. Between 55,000 and 65,000 feet, cosmic irradiation poses no problem. During a transatlantic SST flight, a passenger would receive a much lower total body exposure from this source than from having a

* Professor of Medicine, Indiana University School of Medicine, Indianapolis 46202.

** Professor of Medicine, Indiana University School of Medicine, Indianapolis 46202.

chest x-ray taken.[7] As a result of his studies, Schafer concluded that the irradiation exposure of the individual crew member and passenger in SST's does not pose special problems except for the technicality of classifying SST crew members as "radiation workers,"[8] which results from their recurrent exposures. Solar flare activity could be more serious. Solar flares can cause excessive radiation exposures and cannot be predicted in advance with certainty. The next period of maximum activity will not be until 1969 and it appears that flares giving 4 rem per hour (an excessive dosage) at altitudes of more than 65,000 feet probably will occur less than twice a year.[6] Each aircraft flying above 50,000 feet will carry radiation monitoring systems and when they indicate an excessive exposure, the airplane will descend to lower altitude.[7]

How will the special characteristics of SST travel affect the decision of the physician in evaluating his patient's ability to use this mode of transportation? To be of practical value, the clinical evaluation of these patients cannot depend upon sophisticated, time consuming, highly technical laboratory procedures. An adequate office practice technic described previously for subsonic air travel can be applied here.[3] Essentially, the physician conducts the history and physical examination to assess the patient's ability to perform a certain degree of physical activity comfortably at ground level. He will also frequently use an ECG, a chest x-ray, a blood count, an estimate of the patient's serum electrolytes and carbon dioxide combining power (Table 1). With this information he can arrive at a decision as to the work tolerance of the heart and respiratory apparatus. He can then recommend the maximum safe cabin altitude exposure according to the recommendations of the committee on physiologic therapy of the American College of Chest Physicians.[8] This classification uses arbitrary subdivisions of cabin altitude of 2,000 feet (Tables 2 and 3). It can be seen that the SST maximum cabin altitude of 6,000 feet will be acceptable for most ambulatory patients. Supplemental oxygen can be used by cardiac patients where myocardial oxygenation is marginal and by pulmonary patients where cyanosis exists except for cases of severe chronic obstructive lung disease. In advanced obstructive lung disease, such as emphysema, the danger of carbon dioxide retention makes the unsupervised administration of oxygen potentially dangerous. Patients who suffer from dynamic conditions such as acute pneumonitis or recent myocardial infarction should postpone all travel, including SST travel. Patients with minor arrhythmias, controlled hypertension and mild heart failure (if under adequate treatment) can be expected to tolerate SST travel very well.

Because of the great speed and range of SST's, patients could travel great distances around the earth's surface in a matter of hours and experience a significant time change. It requires two to four days to readjust to the new time, during which there is a disturbance of the circadian rhythm (cyclic variation in body function). The most distressing disturbance is in the sleep-wake cycle and the patient may need medication to aid in sleeping during the adjustment period.

Irradiation will cause no more ad-

OFFICE PRACTICE EVALUATION FOR PATIENT'S ABILITY TO FLY

Procedure	Information Sought
History and physical examination.	Physiologic exercise capability.
Electrocardiogram.	Cardiac ischemia, cor pulmonale.
Chest x-ray film.	Lung pathology, pneumothorax, cor pulmonale.
RBC and/or hemoglobin determination.	Anemia.
Serum electrolytes and carbon dioxide combining power.	Acidosis.

TABLE 1

CABIN ALTITUDE LIMITATIONS FOR PULMONARY PATIENTS

Cabin Altitude	Condition
8,000 feet.	Minimal impairment.
6,000 feet.	Cyanosis + Emphysema. + Restrictive defect. + Diffusion defect.
4,000 feet.	Emphysema + Indications of increased severity.
	Severely affected cyanotic restrictive defect.

TABLE 2

verse effects to the patient than to the healthy traveler. Anticipated protective as well as preventive measures appear to be adequate.

As in today's subsonic aircraft, the patient in an SST will be required to demand little more attention from the cabin attendants than the regular passenger. This concept is reinforced by the extended "seat belt time" of the SST, during which the attention from the cabin crew will be most restricted. If the patient's condition deteriorates in flight, the nearest definitive treatment centers are on the ground and it is possible that the number of airports capable of SST landing to debark such a patient will be limited. However, the time spent in the air generally will be shorter than with today's aircraft.

The operational altitudes of SST's will result in almost no air turbulence with a significant decrease in the incidence of motion sickness. This will remove a significant cause of discomfort, concern and effort.

Summary

In summary, the special characteristics of SST travel will have little effect on the ability of most stable ambulatory patients to use this type of transportation. Because of the 6,000 foot cabin atmosphere, only severely impaired patients with obstructive lung disease who cannot use supplemental oxygen and patients with recent myocardial infarction, severe or unstable angina pectoris and moderate to severe heart failure are not candidates for this type of travel. Whereas the flight pattern of these transports will require longer "seat belt time" (during which there will be less attention from the cabin crew) and will have less availability for emergency landing facilities for hospitalization, the flights will be shorter, smoother and, in general, less exhausting for the ambulatory patient. The possible passage over many time zones probably will require the patient to adjust his circadian cycle at his destination and may require some aid in readjustment of his sleeping pattern. Thus, there is anticipated very little reorientation of the physician's approach to the travel of the ambulatory patient with the advent of SST.

CABIN ALTITUDE LIMITATIONS FOR CARDIAC PATIENTS

Cabin Altitude	Condition
8,000 feet.	Major cardiac disorders with adequate functional reserve at sea level.
6,000 feet.	Cardiac conditions where myocardial oxygenation is marginal.

TABLE 3

BIBLIOGRAPHY

1. Certified Route Air Carriers—Selected Traffic and Financial Statistics—Fiscal Year 1965, Office of Management Services, Data Systems Division of the Federal Aviation Agency.
2. Armstrong, H. G.: Air Travel and Ambulatory Patient, International Forum, Vol. 4, No. 1, *Therap. Notes* 63:13, 1956.
3. Stonehill, R. B.: Air Travel and the Cardiopulmonary Patient, *Postgrad. Med.* 32:387, 1962.
4. Guighard, J. C.: Beyond Mach One, The Medical Aspects of Supersonic Passenger Flying, *Abbottempo* 3:22, 1965.
5. Heppe, R. R., (Chief Engineer—SST, Lockheed—California Company) Personal Communication.
6. Bonnett, G.: Human Factors in the Concord SST, *Aerospace Med.* 36:1094, 1965.
7. Gerathewohl, S. J.: Aeromedical Aspects of the Supersonic Transport: A Review, *Aerospace Med.* 38:1225-1229, 1967.
8. Committee of Physiologic Therapy, American College of Chest Physicians: Report of the Section on Aviation Medicine, *Dis. Chest*, 38:3, 1960. ◄

INDIANA MEDICAL BUREAU
816 Hume Mansur Bldg.
631-5802

A Licensed Employment Agency
Specializing in Medical Personnel

Our 18th Year Of Service

Knee-deep

in osteoarthritic pain

If aspirin doesn't help, move in with Tandearil.

The trial period is brief: 1 week. Try one tablet q.i.d. at first. Tandearil usually starts working within 3 to 4 days. When response occurs, as little as 1 or 2 tablets daily may hold back pain and stiffness, and increase joint motion.

On the next page is a summary of adverse reactions, contraindications, warning and precautions.

Tandearil.
It can help get his mind off his knee.

Please review full Prescribing Information carefully before prescribing.

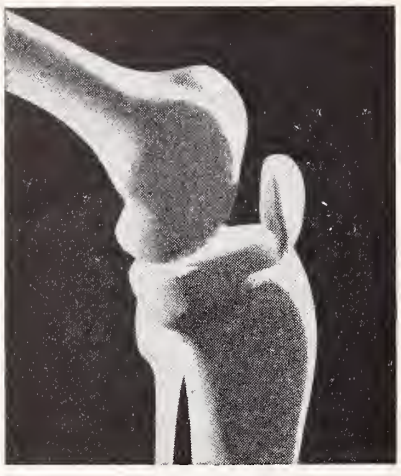
For osteoarthritic knees, spines, shoulders, hips, etc.:

Tandearil®
oxyphenbutazone

andearil, oxyphenbutazone:
or brief summary see next page.

Geigy

TA-6006



Tandearil®
oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

(B)R-46-800-A

For complete details, please see full Prescribing Information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

A new, five-minute test for sickle cell anemia is shown to be accurate, faster and simpler than other existing diagnostic methods.

A New Solubility Test for Rapid Detection of Hemoglobin S

WEI-PING LOH, M.D.
Gary*

THE rapidly growing population of the Negroid race in Gary has increased the author's interest in and experience with hemoglobin S. In recent years, a few unexplained surgical deaths were encountered. Hemolytic reaction or vascular complication due to prolonged hypoxia in the presence of sickle cell hemoglobin was suspected as being one of the important factors in the fatal outcome. It then became clear that detection of abnormal hemoglobin *before* major surgery would help in the selection of anesthesia and prevention of hypoxia.

It is well known that sickle cell hemoglobin (Hb-S) is less soluble than normal adult hemoglobin (Hb-A).[1] On the basis of this differential solubility, it is possible to differentiate between H-A and H-S. The present report describes a new solubility test for the rapid detection of H-S.

Materials and Methods

Reagents for the new solubility test** were provided by the Ortho Research Foundation, Raritan, New Jersey. They consisted of a dried powder and a buffer solution which when mixed gave the working solution. The test was performed by adding 0.02 ml of whole blood (fresh or containing any kind of anticoagulant) to 2.0 ml of the working solution in a 12x75 mm test tube. In the case of severe anemia with a hematocrit of less than 20%, 0.04 ml instead of 0.02 ml of whole blood was used. After 2-5 minutes of incubation at room temperature, the mixture was compared against a negative control containing Hb-A and a positive control containing H-S. A clear solution as seen in the case of Hb-A was recorded as negative for Hb-S and an opaque or cloudy solution was recorded as positive for Hb-S.

Between December, 1967 and September, 1968 the new solubility test and the standard metabisulfite test for detection of Hb-S were performed simultaneously and routinely on a total of 600 adults and children of the Negroid race who were admitted for surgery at the Methodist Hospital of Gary, Inc., Gary. Positive and negative controls were used in the testing.

Results

Analysis of the test results is as follows:

	No. of patients tested
A. Patients negative on both solubility and metabisulfite tests	549
B. Patients positive on both solubility and metabisulfite tests	36
C. Patients positive on solubility test but negative or equivocal on metabisulfite test	15
Total	600

Approximately 10% of the patients in category A who were negative on both tests were studied further with hemoglobin electrophoresis (cellulose acetate microzone method). All of them were found to be negative for Hb-S.

With a few exceptions, i.e., when a young child could not give an adequate specimen, hemoglobin electrophoresis was performed routinely on all patients who had positive solubility tests. In practically all the cases under category B, Hb-S was detected. Two cases showed pure Hb-S, two cases hemoglobins S and C, and the remaining cases Hb-A and Hb-S.

In all 15 cases under category C, the patients had a combination of hemoglobins A and S (sickle cell trait). This indicates that the new solubility test is more sensitive and more reliable than the standard metabisulfite test. This is particularly true when Hb-S is less than 30% of the total amount of hemoglobin.

The sensitivity of this new solubility test was further evaluated in a limited quantitative study using a densitometer and a modified photo-

* Chief pathologist and certified hematologist, Methodist Hospital of Gary, Inc.; also associate professor of pathology at the Chicago Medical School.

** Sickledex®, Ortho Diagnostics, Raritan, N.J.

colorimeter. It appeared that the solubility test can detect as little as 10-15% of Hb-S. Additional study in this direction is in progress.

No false positive or false negative results were seen among the 600 patients tested.

Approximately 8.5% of the 600 Negroid patients studied had Hb-S, identical to the national incidence.[2,3]

No unexpected surgical death occurred during this 9½ months of investigation when the tests for detection of Hb-S were performed routinely on Negro patients before surgery.

Discussion

Both the new solubility test and the standard metabisulfite test are screening tests for Hb-S; electrophoresis is a confirmatory test for the identification of Hb-S. The test results indicate that the solubility test is superior to the metabisulfite sickling test which has a number of inherent inaccuracies as pointed out by Schneider et al.[4] The three tests for detection of Hb-S may be compared as follows:

	Metabisulfite	Electrophoresis	Solubility Test
Sensitivity	good	best	better
Specificity	good	best	good
Time required for completion	few minutes to 24 hours	90 minutes	2-5 minutes
Technic itself	easy	not so easy	easy
Microscope	needed	not needed	not needed
Stability of reagents	poor	good	good (4 wks.)
Interference by poikilocytosis	yes	none	none
Overall cost	low	high	low

Practically all the pre-surgical patients in this investigation were relatively healthy without a severe degree of anemia. We did not have an opportunity to perform the new solubility test in cases of thalassemia, increase of Hb-F, myeloma, other blood dyscrasias, hepatic damage, multiple transfusions, etc. We also did not have the opportunity to compare the new solubility test to the elution test for visualization of Hb-S in blood smears as described by Yakulis and Heller.[5]

Summary

A new solubility test for rapid detection of Hb-S is described and compared with the standard metabisulfite sickling test and electrophoresis. The solubility test was found to be accurate, rapid and easy to perform. It can be easily performed in a doctor's office and can be used for mass testing in a field Hb-S survey because only minimum equipment is needed.

Acknowledgments

The author is deeply indebted to Dr. L. W. Diggs for his valuable advice and to Mrs. Deane McBride, M.T. (ASCP) and her staff for their technical assistance.

REFERENCES

1. Loh, W. P.: Hemoglobins and hemoglobinopathies, *JISMA* 52:2143, 1959.
2. Wintrobe, M. M.: *Clinical Hematology*, 6th edition, Lea & Febiger, Philadelphia, 1967.
3. Harrison, T. R., et al.: *Principles of Internal Medicine*, 5th edition, McGraw-Hill Book Co., New York, 1966.
4. Schneider, R. G., et al.: Sickling tests, pitfalls in performance and interpretation, *JAMA* 202:117, 1967.
5. Yakulis, V. J., Heller, P.: An elution test for the visualization of hemoglobin S in blood smears, *Blood* 24:198, 1964. ◄

Season's Greetings

INDIANA BRACE, INC.

(Phone 923-2351)

1815 N. Capitol Ave., Suite G01, Indianapolis

Lafayette, Indiana

16 N. Earl - Mar Jean Village

In the complex picture of moderate to severe anxiety...

there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-169

Q. How much does the **anticostive*** **hematinic** cost?

A. No more than costive hematinics cost!

The anticostive hematinic is

PERITINIC®

Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:	
● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

*anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. Now isn't that a good idea in an iron-containing hematinic?

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

TAO® (triacetyloleandomycin)

Brief Summary

INDICATIONS: Include staphylococci, streptococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents.

CONTRAINDICATIONS: Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug.

PRECAUTIONS: CAUTION: USE OF THIS DRUG MAY PRODUCE ALTERATIONS IN LIVER FUNCTION TESTS AND JAUNDICE. CLINICAL EXPERIENCE AVAILABLE THUS FAR INDICATES THAT THESE LIVER CHANGES WERE REVERSIBLE FOLLOWING DISCONTINUATION OF THE DRUG.

Not recommended for prophylaxis or in the treatment of infectious processes, which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgment dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including dark-field examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

ADVERSE REACTIONS: Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions.

ROERIG Rx

J. B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
235 EAST 42nd STREET
NEW YORK, N.Y. 10017

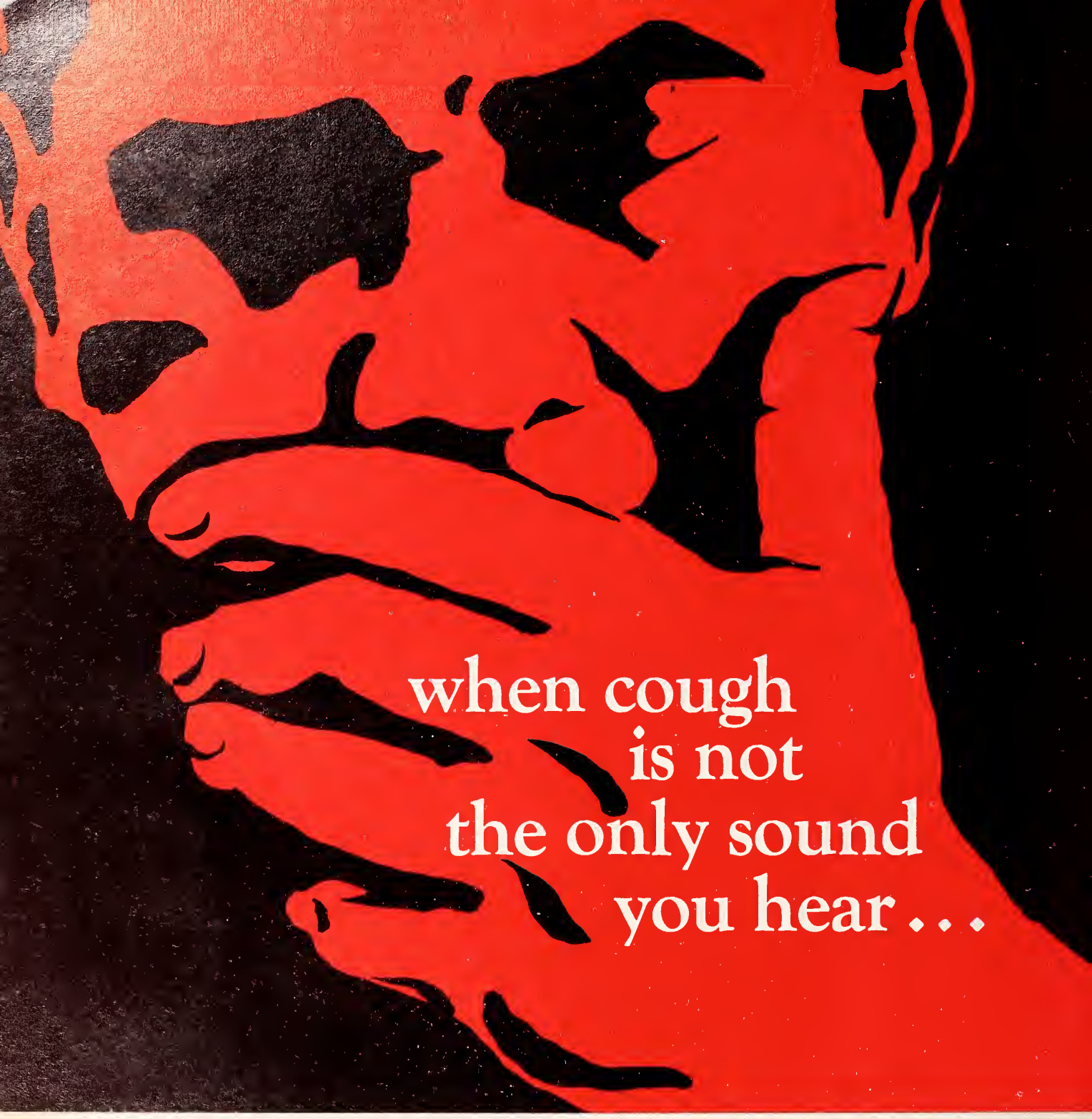
In vitro
susceptibility results
with TAO® (triacetyl-
oleandomycin)
in *Staphylococcus aureus* cultures,
as shown in
studies of
antibiotics.

SUSCEPTIBILITY RESULTS[1,2,3]
Staphylococcus aureus

# OF CULTURES	YEAR	% EFFECTIVE
6,723	1962	88.6%
5,435	1963	88.0%
10,384	1964	88.5%

References: 1. Fowler, J. Ralph et al: Clinical Medicine **70** 547 (Mar.) 1963. 2. Isenberg, Henry D.: Health Laboratory Science **1** 185-256 (July-Aug.) 1964. 3. Isenberg, Henry D. Health Laboratory Science **2** 163-173 (July) 1965.

TAO® (triacetyl-
oleandomycin)
is a macrolide antibiotic, for use only in
the treatment of acute severe
infections where adequate
sensitivity testing has
demonstrated susceptibility
to this antibiotic and resistance
to other less toxic agents.



OMNI-TUSS® b.i.d.

. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.

Gram negative bacilli and staphylococci predominate in traumatic lesions in tornado and auto accident victims. Clostridia were found only in tornado victims. Culture and sensitivity tests are essential to good management.

Infections Encountered in Tornado And Automobile Accident Victims

JOHN H. IVY, M.D.
Elkhart

IN the course of a routine survey by the Hospital Infection Committee, it was observed that a high proportion of infections encountered in tornado victims were caused by gram negative bacilli. Since automobile accident victims constitute the primary and continuing cause for major trauma seen in the hospital, a comparison was made between infections seen in these two groups. All of the infections studied in both groups were acquired outside of the hospital in a population that was in reasonably good health prior to their injuries.

On April 11, 1965, several tornados passed across Elkhart County, Indiana, an area having a population of about 110,000. Included in the path of the tornados were farm homes, a trailer court and urban residential areas. Prior to striking one of the residential areas, one tornado passed through a county garbage dump. This same residential area was served by septic tanks, several of which were opened by the tornado. Other than tourniquets to stop the bleeding, treatment of the injured was not attempted at the tornado site. All of the injured were immediately transported a distance varying from 5 to 10 miles to one of the two hospitals in the county.

One of the greatest immediate problems encountered in treating some of the victims was cleaning them off to ascertain their injuries. It had been raining prior to and during the tornado, and some of the patients were covered with mud that had been forced into all the pores, creases and orifices of the body. After washing them off with soap and water, tetanus toxoid was given to all the victims. Human tetanus antitoxin was given to those who had no previous record of immunization. Patients requiring hospitalization were cared for by physicians selected primarily by chance.

The International Classification of Disease Adapted Category. Road Vehicle Accident (E825), was used to select the automobile accident victims. All patients admitted to one of the hospitals in Elkhart County for the year of 1965 were studied. These included victims of automobile accidents, and some motorcycle and pedestrian accidents. Although an accurate accounting was not possible, the frequency and degree of contamination of the wounds with dirt and filth seen in the tornado accident victims was not seen in the automobile accident victims. Only those persons thrown from an automobile into the dirt would begin to compare with most of the tornado victims.

Results

Of a total of 279 tornado victims treated in the emergency room facilities of the two hospitals, 94 patients were admitted. These patients were compared to 178 road vehicle accident victims admitted to one hospital in Elkhart County for the entire year of 1965. The sex and age distribution and nature of the injury is presented in Table I. As might be expected, the automobile accident group included a large group of men between the ages of 10 and 39. The tornado victims were more evenly distributed as to sex and age.

The automobile accident victims had a greater proportion of central nervous system injuries. The presence of burns in this group might have caused an unusual predisposition to infection, but in fact, only one culture was done and it showed a hemolytic streptococcus and an enterococcus that was considered to be hospital acquired and, therefore, not included in this study. The ruptured organs include liver, spleen, kidney, intestines and lungs, and may have been the source for a bacteremia in a few instances.

There was no marked difference in the frequency of lacerations, contusions or abrasions in these two groups, but a large number of these injuries in the tornado victims were severely contaminated. The frequency of amputations in the tornado group reflects the presence of crushed and contaminated extremities. Of the six deaths among the tornado victims, only one may have been related to infection. Two died from brain damage and three from shock related to blood loss. The frequency of shock seen in the tornado victims may be related to the greater severity of in-

COMPARISON OF THE TWO GROUPS STUDIED

	Tornado Accidents April 11, 1965					Automobile Accidents for 1965				
	(Age Group)				Total	(Age Group)				Total
	0-9	10-39	40-59	60 & over		0-9	10-39	40-59	60 & over	
Male	14	16	10	7	47	5	85	15	6	111
Female	7	22	8	10	47	10	44	8	5	67
Laceration, contusion, abrasion	17	33	15	13	78	10	97	15	6	128
Fracture, non-compound	10	21	12	11	54	8	64	16	7	95
Fracture, compound		5	1	3	9	1	10			11
Sprain and dislocation							12	2	1	15
Ruptured organ		1	1		2		4	4		8
Central nervous system injury	5	5	5	1	16	8	40	4	4	56
Amputation	1	3	2		6					
Burn							5			5
Shock	1	4	2	3	10		4	1		5
Wound culture	4	13*	7	4	28		3	2		5
Deaths in hospital	1	2	1	2	6	2				2
TOTAL					94					178

* Includes one blood culture.

TABLE I

jury sustained by this group.

One of the outstanding differences seen in Table I is the greater number of wound infections in the tornado victims that were severe enough to require a culture and sensitivity test to guide the physician in treatment. Only one positive culture was from blood and it demonstrated a gram positive bacillus. Hospital acquired infections were not tabulated; they amounted to three infections in the tornado and four infections in the automobile accident victims. The frequency and type of the organisms cultured is presented in Table II. The preponderance of enterobacteria in both the tornado victims (66%) and the automobile accident victims (58%) is apparent. Staphylococci, mainly penicillin resistant, were the next most frequent: 14% in tornado victims and 25% in auto accident victims. The nine cases of Clostridium perfringens infections were found exclusively in the tornado victims.

The cultures demonstrated a mixture of organisms, varying from two to six types. Pure cultures were obtained in six cases which included a yeast-like fungus, two coagulase negative staphylococci, a coliform bacillus and two cases of Proteus. Six of the eight coagulase negative staphylococci were associated with enterobacteria and/or coagulase positive staphylococci. One or more of the enterobacteria were present in 29 of the 33 cases cultured.

The antibiotic sensitivities of the bacteria cultured were determined with the use of commercial discs and followed the expected pattern. All of the Clostridium perfringens tested were sensitive to penicillin. Only four of the 16 staphylococci were sensitive to penicillin, but most were sensitive to oxacillin, chloramphenicol and erythromycin. The coliform organisms were sensitive to colistin and 80% or more were sensitive to the tetracyclines and chloramphenicol. A similar sensitivity was noted for the enterococci and paracolon. The enterococci were very sensitive to ampicillin. Only 50% of the Proteus were sensitive to chloramphenicol and streptomycin. Sensitivity to kanamycin was not determined. Only 11% of the Proteus were sensitive to ampicillin. All of the Pseudomonas organisms were sensitive to colistin and resistant to most other antibiotics.

The therapy of mixed infections is difficult to evaluate. On the basis of the antibiotic sensitivities, it was felt that the antibiotic therapy was effective in 20 cases, partially ef-

FREQUENCY OF ORGANISMS CULTURED

	Tornado Victims 28 cases			Automobile Accidents 5 cases		
	Number	Total	Percent of Total	Number	Total	Percent of Total
Streptococcus:		5	5.4%			
Strep. viridans	1					
Non-hemolytic	3					
Hemolytic, Group A	1					
Staphylococcus:		13	14.0		3	25%
Coagulase positive Penicillin sensitive	1			1		
Penicillin resistant	6					
Coagulase negative Penicillin sensitive				2		
Penicillin resistant	6					
Enterobacteria:		61	65.6		7	58.3
Coliform	23			2		
Pseudomonas	2			1		
Proteus	16			1		
Paracolon	5			2		
Enterococcus: Hemolytic	3					
Non-hemolytic	12					
Alcaligenes fecalis				1		
Gram positive bacillus	1*	1	1.7	1	1	8.3
Clostridium perfringens	9	9	9.7			
Yeast-like fungus	4	4	4.3	1	1	8.3
TOTAL		93			12	

* The only blood culture; all of the others from wounds.

TABLE II

fective in eight cases and ineffective in five cases. From two to seven different antibiotics were used in 25 of the 33 cases cultured. Penicillin was used in eight of the nine cases of Clostridium perfringens infection. The only exception occurred in a patient allergic to penicillin. Definite gas gangrene occurred in one case with a severely mangled leg. An attempt to reconstruct the vascular supply was made, but was unsuccessful and this, plus the gas gangrene, necessitated amputation. Gas gangrene was suspected in two additional cases.

The effect of antibiotic therapy on morbidity was not evaluated because of the multiplicity of possible causes. Of the six deaths, one may have been related to infection. The difficulty of assigning an exact cause is illustrated by the following case. This occurred in an obese, middle-aged woman who had multiple injuries including a cerebral concussion, bilateral pulmonary and mediastinal hemorrhage, a fracture of the left scapula and acromion process and marked blood loss from several very large lacerations. There was little blood loss after her arrival at the hospital because of the persistent shock from which she never did recover. She lived for two days during which time the blood pressure and urinary output did not fully respond to the use of intravenous electrolytes, plasma, dextran and blood. She was also given vasopressors, oxygen therapy and digitalis. Penicillin G in a dose of 1,000,000 units twice daily was ad-

FREQUENCY OF ANTIBIOTIC USE

	With Culture (Number)	(Percent)	Without Culture (Number)	(Percent)
Penicillin	25	34%	71	45%
Tetracyclines	17	23	28	18
Sulfas	1	1.3	15	9.5
Erythromycin	5	7	18	11
Chloramphenicol	11	15	7	4.5
Streptomycin	9	12	12	7.6
Lincomycin	1	1.3	2	1.3
Ampicillin	4	5.5	3	1.9
Staphicillin	0	0	1	0.6
TOTAL	73		157	

TABLE III

ministered. A terminal fever of 104.8 developed and a blood culture reported at about the time of death showed a gram positive bacillus that was sensitive to chloramphenicol, erythromycin and streptomycin. The gram positive bacillus was not identified further and its part in this woman's death is questionable. The extent of her injuries alone could have accounted for her death. If the gram positive bacteremia were a factor in her death, it was felt that chloramphenicol would have been more effective than penicillin. The need to use antibiotics before the results of culture and sensitivity tests are available is common. In the case of a gram negative bacteremia, the mortality is notoriously high[1] and therapy with an effective antibiotic must be instituted promptly to have any effect at all.

Table III demonstrates the difference in frequency of use of various antibiotics when bacterial cultures and antibiotic sensitivities were or were not available. The increased use of tetracyclines, chloramphenicol, streptomycin and ampicillin probably resulted from the finding of a high percentage of enterobacteria when the wounds were cultured.

Discussion

The rising incidence of hospital infections caused by gram negative bacilli has been well documented.[2-7] The emphasis in these studies has been on seriously ill patients with bacteremia, the majority of infections having been acquired in the hospital. This study demonstrated the high incidence of infections due to gram negative bacilli found in wounds caused by a tornado and in automobile accident victims. No reports of the types of infections encountered in victims of other tornado disasters were found. The bacterial cultures obtained in this study, however, resemble the findings in war wounds.[8-10] Most of the war wounds encountered were mixed infections and had at least three species of bacteria. Clostridium organisms were present in from 15% to 40% of the wounds. In the Korean War, more Clostridium organisms were found during the summer months (44%) than in the winter months (21%). This difference was attributed to the inhibiting effect of the frozen ground on bacterial growth, plus lessened contamination of wounds. A similar seasonal difference was noted in the enterobacteria. Enterobacteria were found in about 20% to 25% of wounds and were considered to be of low pathogenicity. It was concluded that all war wounds were contaminated and that the incubation period was from six to 12 hours. During the first week, the most prevalent organisms were the sporulating anaerobes and the streptococci of fecal origin. During this first week, gas gangrene and tetanus were likely to occur. During the second week, both pyogenic and fecal organisms were prevalent. After the third week, staphylococci and streptococci were most prevalent. With few exceptions, the cultures in this study on tornado and auto accident victims were obtained during the first two weeks after injury, and the findings parallel those of war wound studies.

The routine treatment used on the Eastern Korean battle front in severely contaminated wounds was penicillin, tetanus toxoid, bacterial culture and debridement.[8] Although one tornado does not make a rule, the 10% incidence of Clostridium perfringens in wounds and one clinical case of gas gangrene emphasize the need to keep this possibility in mind. The high incidence of enterobacteria in the wounds of both tornado and automobile accident victims emphasizes the need for bacterial culture and antibiotic sensitivity tests on all severely contaminated wounds. Since most wounds contained mixed bacteria, the use of penicillin plus a board spectrum antibiotic would be appropriate. Although antibiotics should be started immediately on all patients with grossly contaminated wounds, the antibiotic sensitivity of the enterobacteria varies and sensitivity testing may be necessary to administer effective treatment.[6,7,11]

Summary and Conclusions

1. The frequency of clinically infected wounds among the victims of one tornado greatly exceeded those among victims of automobile accidents which occurred during the same year.

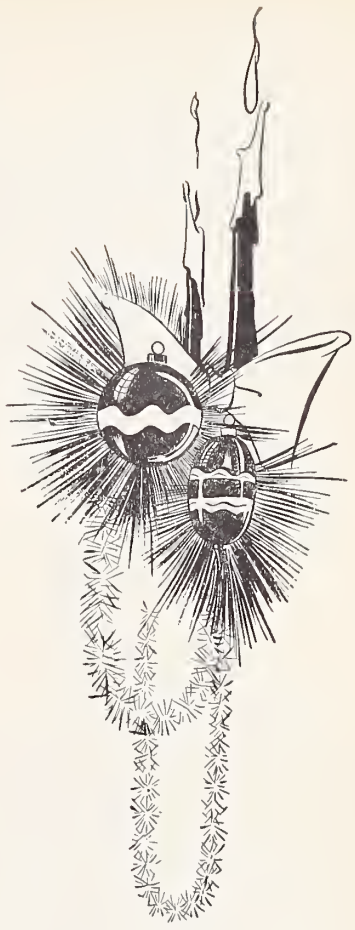
2. The incidence of enterobacteria in clinically infected wounds was 66% in tornado victims and 58% in automobile accident victims.

3. Bacterial culture and antibiotic sensitivity determinations are an important adjunct in the proper treatment of contaminated wounds.

BIBLIOGRAPHY

1. Weil, M. H., Spink, W. W.: The Shock Syndrome Associated with Bacteremia Due to Gram-Negative Bacilli, *Arch. Int. Med.* 101:184-193, 1958.
2. Rogers, D. E.: The Changing Pattern of Life Threatening Microbial Disease, *New Eng. J. Med.* 261:677-683, 1959.
3. Finland, M., Jones, W. F., Jr., Barnes, M. W.: Occurrence of Serious Bacterial Infections Since the Introduction of Antibacterial Agents, *JAMA* 170: 2188-2197, (Aug. 29), 1959.
4. Finland, M.: Treatment of Pneumonia and Other Serious Infections, *New Eng. J. Med.* 263:207-221, (Aug. 4), 1960.
5. Yow, E. M.: Clinical Significance of Rising Incidence of Infections Due to Gram-Negative Bacilli, *Postgrad. Med.* 17:413-419, 1955.
6. McCabe, W. R., Jackson, G. G.: Gram Negative Bacteremia, *Arch. Int. Med.* 110:847-864, 1962.
7. McHenry, M. C., Martin, W. J., Wellman, W. E.: Bacteremia Due to Gram Negative Bacilli, *Ann. Int. Med.* 56:207-219, 1962.
8. Lindberg, R. B., Wetzler, T. F., Marshall, J. D., Newton, A., Strawitz, J. G., Howard, J. M.: The Bacterial Flora of Battle Wounds at the Time of Primary Debridement, *Ann. Surg.* 141:369-374, 1955.
9. Rustigian, R., Cipriani, A.: The Bacteriology of Open Wounds, *JAMA* 133:224-230, (Jan. 25), 1947.
10. Altemeier, W. A.: The Bacteriology of War Wounds, *Internat. Abst. Surg.* 75:518-533, 1942.
11. Sweeney, F. J., Rodgers, J. F.: Therapy of Infections Caused by Gram Negative Bacilli, *Med. Clin. N. Amer.* 49:1391-1402, (Sept.), 1965. ◄

The Elkhart Clinic
405 S. Second St.
Elkhart 46514



A hospital for the diagnosis and treatment of psychiatric illness

WABASH VALLEY HOSPITAL

(a not for profit corporation)

2900 North River Road (State Road 43 north)

West Lafayette, Indiana 47906 Phone 317-463-2555

Active Psychiatric Staff	(Phone)
W. R. VanDenBosch, M.D.	447-6404
David L. Evans, M.D.	447-9155
Joe M. Martin, M.D.	463-2695
Edgar C. Stuntz, M.D.	
Limited private practice	
John H. Wilms, M.D.	
F. H. Spurlock, M.D.	749-2441
Alfred R. Heasty, M.D.	

Robert K. Jones, Ph.D.
Clinical Psychologist

Mrs. Margaret Keedy, A.C.S.W.
Psychiatric Social Worker

Elizabeth J. Snyder, R.N.
Director of Nursing Service

James Jones, B.P.E.
Director of Activity Therapy

Donald R. Kinzer, Hospital Administrator

John Sterzer, Business Manager

Admissions are arranged through referral to any active staff psychiatrist.

All general medical and surgical specialties in the community are available through physicians on the open consulting staff.

ELECTROCARDIOGRAM OF THE MONTH

PAT with Block Due to Digitalis

CHARLES FISCH, M.D.
Indianapolis

DIPHENYLHYDANTOIN has been shown to be a useful adjunct in the treatment of digitalis induced arrhythmias. The accompanying figure was recorded in a patient after administration of fairly large amounts of digitalis. The basic rhythm is one of paroxysmal atrial tachycardia with block with a rate of 150 per minute and a 1:1 response in the top strip. In the second strip the A-V conduction varies between 1:1 and 2:1. The fourth and fifteenth QRS complexes are aberrant. The aberrancy is due to prolongation of refractoriness secondary to longer, immediately preceding R-R intervals.

Sinus rhythm was restored by intravenous administration of 250 mg. of diphenylhydantoin.

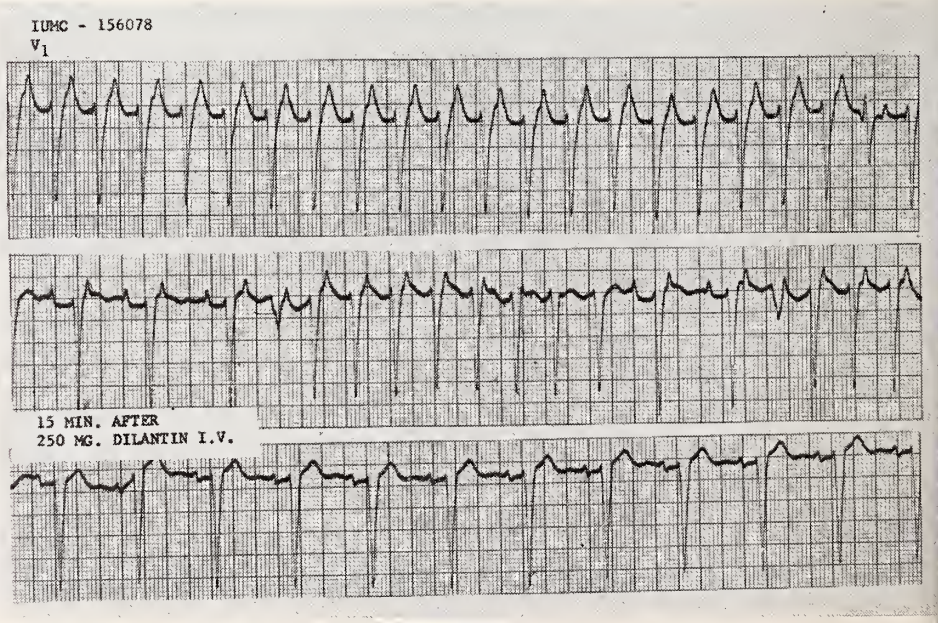


FIGURE 1
PAT with block responding to intravenous administration of diphenylhydantoin.

* From the Krannert Institute of Cardiology, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.

THE EARLY SYMPTOMS OF OSTEOPOROSIS

low back pain
muscle spasm

OFTEN RESPONO TO CALCIUM THERAPY

In postmenopausal and geriatric patients, low back pain of unspecified origin may be symptomatic of the early stages of osteoporosis and calcium depletion. Treatment with Calcium-Forte, a form of calcium readily available for absorption, may help to restore a positive calcium balance. In doing so, often it can alleviate the symptoms and help to arrest the progress of osteoporosis by preventing further skeletal damage.

One packet of Calcium-Forte contains the equivalent of 500 mg. elemental calcium, the same amount found in one-half quart of milk.

☐ pleasant tasting ☐ highly concentrated
☐ readily soluble

Indications: As an adjunctive measure for major calcium depletion states, which require elemental intakes higher than normal dietary supplements can provide, such as the initial stages of postmenopausal and senile osteoporosis and advanced osteoporosis; also adjunctively with Vitamin D for the treatment of mild or latent hypocalcemic tetany.

Contraindications: Lithiasis, hypercalcemia, cardiac or renal failure.
Precautions: If the patient has a history of renal disease, administration of Effervescent Calcium Granules should be accompanied by abundant intake of acidulous liquids such as fruit juices to avoid hypercalciuria. Should hypercalciuria occur, dosage should be reduced accordingly. Due consideration should be given to the sodium content of Effervescent Calcium Granules when treating patients requiring low sodium diets.
Side Effects: In high doses may cause indigestion or diarrhea. Constipation may occur occasionally.
Composition: Each packet of orange-flavored Effervescent Calcium Granules contains 2.94 grams of the double salt calcium lactate-gluconate and 0.30 grams of calcium carbonate (also contains 325 milligrams of sodium per packet).

New
CALCIUM-FORTE
(Effervescent Calcium) Granules

SANDOZ PHARMACEUTICALS, HANOVER, N.J. SANDOZ

68-207

X-RAY CONFERENCE

Diagnosis of Metastatic Disease to the Obturator Nodes in Carcinoma of the Cervix

ERICH K. LANG, M.D.
Shreveport, La.*

THIS 47-year-old colored female was referred for radium therapy with the diagnosis of carcinoma of the cervix, stage IB. Physical examination revealed a fairly typical endocervical lesion, which was again classified as a IB. There did not appear to be any extension into the parametrium. The pelvis otherwise appeared to be negative.

Intravenous pyelograms and double contrast barium air cystograms were performed, but failed to show any significant abnormalities.

A pelvic arteriogram demonstrated elongation of the cervical branch of the left uterine artery. A very faint tumor blush was noted on the late phase films in the left cervical region. The blush did not appear to extend into the parametrium. The most significant finding, however, was limited to the right obturator fossa. A very densely staining node was demonstrated on the 8 to 11 second delayed films (Figure I). The staining pattern of the node was not characteristic for tumor and since inflammatory disease could not be excluded, the obturator fossa was explored and several large nodes removed. Histological section unequivocally proved the presence of carcinoma in these nodes. In the absence of any other neoplastic lesion in the drainage area of these nodes, it was concluded that this represented metastatic disease of the known carcinoma of the cervix to the obturator nodes.

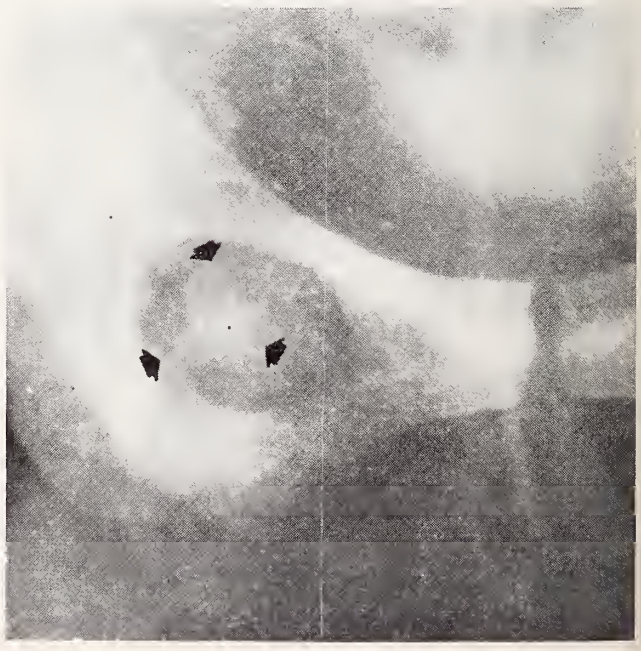


FIGURE 1
A LATE phase roentgenogram shows dense staining of the node in the right obturator fossa. The appearance is felt to be suggestive of neoplastic involvement of the obturator node group.

Comment

Arteriography as been primarily employed for assessment of tumor extension of carcinoma of the cervix into the parametrium. The method offers an excellent modality to demonstrate minor extension of neoplastic lesions that may evade detection by routine physical examination. The staining characteristic of carcinoma of the cervix is unfortunately indistinguishable from some inflammatory lesions. Hence, the information derived from arteriograms is often invalidated by the presence of significant inflammatory disease.

Nonetheless, the method has been opportunely employed for the assessment of tumor extension in large patients difficult to examine by bimanual examination and, in the recent past, has demonstrated tumor in distant nodes that would have normally evaded detection. The method has been found particularly useful for the assessment of iliac nodes, habitually difficult to diagnose by bimanual examination. Limited experience with the staining characteristics of implants of carci-

* Professor and Chairman, Department of Radiology, L.S.U. School of Medicine, Confederate Memorial Medical Center, Shreveport, La. 71106.

noma of the cervix to pelvic nodes has necessitated the surgical confirmation and histologic examination of the suspect node groups. It is conceded that inflammatory disease of the pelvis may mimic neoplastic disease. However, inflammatory disease usually results in staining of most of the nodes on arteriograms whereas neoplastic disease will stain only those isolated nodes that show neoplastic invasion. ◄

I.U. School of Medicine Postgraduate Courses
(Division of Postgraduate Medical Education)

DATE	COURSE TITLE	LOCATION	COURSE DIRECTOR
Jan. 15	Acute Cardiology	Marion County General Hospital	Charles Fisch, M.D.
Feb. 12	Emotional Problems of Young People	Ball State University, Muncie, Ind.	Wayne G. Pippenger, M.D.
Feb. 12	Modern Therapy of Cancer	I. U. M. C.	Robert Rohn, M.D.
Feb. 19	Management of Pediatric Handicaps	I. U. M. C.	Morris Green, M.D.
Mar. 5	Therapy of Chronic Obstructive Lung Disease and Bronchitis	I. U. M. C.	Roy Behnke, M.D.
Mar. 13/14	Community Neurology	I. U. M. C.	Joseph Green, M.D.
Mar. 19, 20, 21	Electrocardiography for Physicians	I. U. M. C.	Donald Close, M.D.
Mar. 24, 25, 26	Electrocardiographic Interpretation of Arrhythmia	Marion County General Hospital	Charles Fisch, M.D.
Mar. 26	Ophthalmology for the General Practitioner	I. U. M. C.	Fred Wilson, M.D.
April 2	Management of Congenital Anomalies of Skin and Soft Tissue	I. U. M. C.	James Bennett, M.D.
Apr. 15, 16, 17, 18	Radiology of Trauma	I. U. M. C.	John Campbell, M.D.
Apr. 13-Apr. 27	Anatomical and Clinical Otolaryngology	I. U. M. C.	David Brown, M.D.
April 23	Management of Common Dermatologic Conditions	Marion County General Hospital	Victor Hackney, M.D.
May 13/14	Indiana Multidisciplinary Child Care Conference	Stouffer's Inn	Morris Green, M.D.
May 22	Psychiatry in Everyday Practice	Elks Country Club, Sullivan, Ind.	Betty Dukes, M.D.

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 1802 North Illinois Street, Indianapolis, Ind. 46202.

Assaciate Editors: A. W. Cavins, M.D., 221 Sauth Sixth Street, Terre Haute; Lall G. Montgomery, M.D., Ball Memorial Hospital, Muncie; David A. Bickel, M.D., 515 Odd Fellaws Building, South Bend; Samuel R. Mercer, M.D., 702 Medical Center Bldg., Fort Wayne; I. W. Wilkens, M.D., 1743 Shelby St., Indianapolis.

Editarial Board: Term Expires

Alvin J. Haley, M.D., Fart Wayne . . . . Dec. 31, 1968
Wei-Ping Loh, M.D., Gary . . . . . Dec. 31, 1968
Jack W. Hickman, M.D., Indianapolis . . . Dec. 31, 1969
Frank H. Cable, M.D., Richmand . . . . . Dec. 31, 1969
Jene R. Bennett, M.D., South Bend . . . . Dec. 31, 1970
W. D. Snively, Jr., M.D., Evansville . . . . Dec. 31, 1970

Assistant Editor: Jackie Freers Stahl
Business Manager: James A. Waggener
3935 N. Meridian, Indianapolis, Indiana 46208.

Partners of the Alliance

THE Partners of the Alliance was organized in 1964 to provide a structure through which the private sectors of the United States and Latin America could establish workable lines of mutual communication and economic and social self help.

Today the Partners are active in 37 states and 15 Latin American nations.

Each state deals with one Latin American country or province. The work of the Partners is concentrated in four fields: education, health, agriculture, and business and industry. Aside from travel funds voted by Congress, all Partnership projects are carried out with private funds.

The National Association of the Partners of the Alliance was formed in 1967 with headquarters in Washington, D. C., to coalesce the work of the state organizations in all practical ways.

In the field of agriculture, the work of the Partners North and South is devoted largely to helping increase the food production of the Latin American countries. While a land of plenty has not been developed as yet, a good start has been made.

They have introduced, on a limited scale, better seeds and stocks, improved techniques and tools, soil analysis and fertilizers and improved marketing. Northern partners have helped to organize cooperatives and have set up revolving small loan funds, all with private money.

Six farmers from the Brazilian state of Rio Grande do Sul will visit Indiana next spring. They will live in the homes of Indiana farmers for two weeks and study farming and stock raising methods. The Indiana Farm Bureau is cooperating in the planning. The Brazilians are particulary interested in the techniques of raising corn and soy beans. These are their two most important crops but their yield is less than half that obtained here.

Second Interim Report of the HEW Task Force on Prescription Drugs

PUBLICATION of the above titled Task Force Report has prompted a detailed discussion and critique by the Pharmaceutical Manufacturers Association.

PMA President C. Joseph Stetler, while acknowledging the magnitude of the subject, felt that the report was confusing because it ranged too far from its main assignment which in itself was extensive enough.

Mr. Stetler charged that the Task Force relied too heavily on testimony before subcommittees of Congress. Practically all such testimony has been produced by witnesses who were invited by investigators who were seeking "friendly" testimony. Many witnesses who desired to testify to the contrary have not been admitted to the hearings.

The association disagreed with many of the conclusions, chief among which were those dealing with drug prices, industry profits, promotion and marketing, research, patents competition and clinical equivalency.

The PMA praised the report for its "important and possibly original contributions" to the problem of health needs of the elderly, and pledged its support to exploration of the social needs of those with limited incomes.

The Task Force Report, without explanation, cited "independent surveys" to document the trend in drug prices. Although the figures given show that drug prices are increasing at a rate less than the cost of living the Task Force does not mention the Bureau of Labor "market basket" price study which has shown the true price of pharmaceuticals as decreasing steadily. The Labor "price level" study is based on current selection of drugs and reflects accurately what consumers actually spend for drugs.

Another inconsistency in the re

port is that the prices of generic drugs are compared with those of brand name products, but not the same products. The generic list consisted of older, less expensive products—products which would have cost less whether in generic or brand name form.

The study on clinical equivalency did not produce valid results since most of the generic forms used for comparison were actually brand name products sold to government agencies on generic name bids. Many of the comparison tests were also invalidated because they were made on drugs with different formulations.

The report failed to assess honestly the great importance to modern pharmacology of "molecular modification." It implied a condemnation of "messing with the molecule" to a complete disregard of the major advances in steroid pharmacology to mention but one example.

The Task Force published a fallacious figure of a $600,000,000 promotion expenditure for the industry as a whole, and alleged that this amounted to $3,000 per doctor annually. As a matter of fact, the total for all promotion, marketing and distribution for 100 companies with extensive marketing operations is below this figure. The actual total amounts to only $16 for each doctor, dentist and pharmacist in the country.

Mr. Stetler points out that the report indicates an unsympathetic attitude toward patents. Research and development expenses are now ten times what they were ten years ago. The PMA position is that adequate patent protection is necessary for the recoupment of R&D investment involved in both successful drugs and for entities that never reach the market.

The report also must register an unsympathetic attitude toward physicians. Mr. Stetler says "The report is indefensibly pessimistic about the competence of practitioners of medicine."

The report implies that what the physician needs, as an aid in his understanding of drugs, is a government printed reference book. Mr. Stetler says "What is needed is far from another publication by the government, but rather additional private mechanisms (or better organization of present ones) for the free communication of medical ideas."

Guest Editorials

The Fifty-Year Club*

J. O. RITCHEY, M.D.
Indianapolis

MR. President, distinguished guests and members of Indiana Medical Association:

You have asked me to respond for our group—those who have had the good fortune to practice medicine for 50 years. We are grateful to you for your felicitations at this milestone—though there might be a serious question whether one's age should be publicly announced. Everyone knows the time is coming, but no one thinks it will be so soon.

It all started in 1918. There were many who started with us, but time and the natural way of life has sharply limited our numbers. For those departed, we salute their memory. There are some who because of infirmities cannot be with us tonight. To them we offer deep sympathy and our prayers for their comfort. And we, the fortunate few even though candidates for Geritol, thank our lucky stars that a kind providence has spared us.

In that memorable year 1918 we were just emerging from the horse and buggy days and into the machine age. From there we entered the space age—no telling what will follow.

We also witnessed the passage by Congress and ratification by states—the Volstead Act—and with it the emergence of huge crime gangs and mobs. Even though the noble experiment ended in a fizzle and repeal—crime and gangsters continue to grow and thrive. We have seen Republicans and Democrats in the White House come and go—but mostly Democrats.

During and since 1918 we have been through two world wars and God knows how many police actions.

We have seen the population explosion and the emergence of the beatniks, the hippies, the miniskirts and the birth of "the pill."

Shortly after our graduation came Banting and Best with insulin. Sharply following came such a profusion of medical knowledge that overshadows all medical history prior to our 50 years. During that time many medical problems have been resolved, but they in turn have raised countless other problems awaiting solution.

The impact of all this on medical education has all but revolutionized its format. It has also phenomenally changed the practice of medicine. It has meant study, adjustment and adaption to new knowledge, new methods and new concepts. Even death itself needs new definition.

In those days doctors went to see their patients and, as often as not, at night. Yes, the practice of medicine has changed. What the final impact of all these changes on society will be, only time will tell. Recent events indicate more and more government in the picture will occur.

And now at the end of the 50-year saga, I should like to close with the following lines:

Blood, sweat and tears
For fifty years
Have left a mark on our careers,
If our careers can lend a spark
and penetrate the abysmal dark.
ignorance and pain,
Then let us hope we've made a gain
And fifty years is not in vain.
The only part that we deplore
We haven't time for fifty more.

* Response made at the induction of the 1968 class of the Fifty-Year Club at the President's Dinner, October 16, 1968, at Fort Wayne.

The Chicago Convention and Socialized Medicine

THREE years ago, when socialized medicine was foisted upon a gullible public, the question was frequently asked as to just what manner of man was willing to reduce American medicine to the status of nationalized medicine in Great Britain. The answer to this question was evident to anyone who followed the proceedings within and without the International Amphitheatre in Chicago during the recent convention. It is hazardous to judge the intelligence of an individual by his physiognomy, but when nearly three thousand dull and vacuous faces are mercilessly exposed by the searching television camera, it is impossible not to believe that seldom has an enclosure contained so many intellectually underprivileged persons. Beyond the barbed wire enclosure, the scum of America, whelped during the present administration, which is now asking for a vote of confidence, rioted and added to the general chaos.

A few delegates who mounted the podium looked the part of Americans whom one would like to see in public life. The vast majority were uniformly undistinguished. But it cannot be said that there were not occasional bright spots in the overall prevailing drabness. The permanent chairman, who responded to every question from the floor, other than the most routine, by calling upon the band to play during his pedestrian thinking, at least provided some welcome music at frequent intervals. The chairman of the New Hampshire delegation, who relished the opportunity to explain to the TV audience how he managed to become arrested, handcuffed and carted off in the paddy wagon for monkeying with the electronic admission device and later with the policeman who remonstrated with him, momentarily relieved the tedium of the final evening. Probably the most constructive idea was contributed by the jigsaw artist who cut out the outlines of the various states. This generous man almost doubled Virginia's area by adding West Virginia and thus restored the Old Dominion to its ante-bellum status.

The platform committee, of course, preened itself in recounting the role of the present administration in the passage of Medicare three years ago. If the new party platform is examined further we find that "Medicare for the aged should be expanded. . . ." The platform also urged that existing medical programs be extended to finance additional prenatal care for mothers and post-natal care for children during the first year of life. The nose of the camel, or rather the nose of the donkey, is now completely within the tent and the remainder of the beast is not far behind.

The answer to the question, asked in the beginning, as to what sort of person wishes to see American medicine sacrified on the altar of political expediency was evident in Chicago for all the world to see. The physicians of Virginia are aware of it. Let us be sure that our patients also have received the word.—**Harry J. Warthen, M.D., Chairman and Editor,** *The Virginia Medical Monthly* **95:649, October, 1968. (Reprinted with permission.)**

Medical Ethics

THE late Homer Pearson, M.D., a past chairman of the American Medical Association's Judicial Council, said, "Medical ethics are basically the same as ethics for any other homologous group of people working together in a common cause."

The import of this thought may not be fully appreciated. There are ethical principles which guide, or should guide physicians as men, as rational beings possessing free will. These principles, as they become known, and, as they are applied, are guidelines for man, not simply guidelines for doctors, merchants, bankers, homemakers or any special or particular group within society.

Abortion, for example, is not essentially a matter of *medical* ethics; it is a matter of ethics. It, like many other subjects within the realm of ethics, is a matter about which the physician may have special knowledge and experience, but this special knowledge and experience does not create a medical ethic.

In this area, as in many others, the practice, discipline and professionalism of the physician must reflect itself in the application of accepted, ethical norms in the practice of medicine.

The physician, as a citizen, must be an ethical man and comport himself in accord with the accepted ethical standards that apply to all men. He must know and apply accepted ethical standards, and he must contribute to the proper enunciation of new principles and the clarification of old principles. This he can and must do within his area of competence.—**AMA Service Brief.**

Editorial Notes . . .

The best way to stop smoking is never to start. Polls taken of teen-agers and their smoking habits shows that, for the first time, fewer teen-agers are smoking and more of them are indicating that they definitely do not plan to start. Ninety-one percent of the group polled said they believed smoking to be harmful.

Medicare, in the first two years, has paid in excess of $150 million for medical services to Hoosiers said Byron Goetz, the regional commissioner, recently. Mr. Goetz praised doctors, nurses, hospital administrators, extended care facilities, home health agencies and the Indiana State Board of Health for cooperation which has made the program a financial success. There are now 139 hospitals, 77 extended care facilities and 28

home health agencies participating in Indiana.

C. Joseph Stetler, president of the Pharmaceutical Manufacturers Association, favors the improvement of existing drug compendia, rather than the construction of an entirely new one. Only 15% of physicians in private practice favor a new one, 64% believe existing sources are adequate and 21% prefer revision or expansion of existing works. Four out of five physicians answering the survey said they used PDR most often. One in ten refers to *The Medical Letter*, the *Merck Manual* and the AMA *New Drugs*. The PMA favors expanding the PDR to include a separate list of the most often prescribed generic forms, thinks that additional drugs should be added, and that every piece of negative information about a drug contained in the approved package insert be a required part of the PDR entry. The survey was conducted by the Opinion Research Corporation under the sponsorship of PMA.

A faculty committee of Harvard University, composed of representatives of the faculties of medicine, public health, divinity and arts and sciences has announced in the public press its decision that it is the responsibility of the attending physician to determine the fact and time of death. The ruling was made necessary by the ability of life-support mechanisms to simulate the appearance of life in a subject devoid of central nervous system functions.

The price of drugs, and especially prescription drugs, is continuing to decline. The Department of Commerce has announced that, in 1967, the average consumer spent only 13.3 cents of his medical care dollar for drugs. The figure ten years ago was 16.4 cents.

Bikini, a name long famous in the world of apparel, will soon become known again as a place of residence. The Atomic Energy Commission has monitored the radioactive status of the atoll at intervals since the last nuclear test in 1958, and now finds that the Bikinians may be moved back. The natives were moved away in 1946, prior to the first test. The degree of radioactive safety varies from island to island. Food crops may now be grown safely on Eneu. Any buildings built on Bikini island must have a base of coral rock as protection. Land crabs will be eliminated because of their high content of strontium 90. If pandanus trees are planted, two inches of topsoil must be removed from the planting sites. Powdered milk as a dietary supplement will be supplied the population in order to elevate the calcium intake and reduce the strontium 90 uptake. Careful radioactive surveys will be continued.

Drug prices and the cost of living continue to go in opposite directions. Latest Bureau of Labor retail drug price index shows a decrease of 11.6% from the base of 1957-59. The all-items Consumer Price Index during the same time has risen by 19.5%. Antibiotics lead the price decline. The Firestone index shows that patented drugs have fallen to 74.5% of the 100 base while non-patented drug prices are at 101.1%.

Steve Hamilton, 14-year-old son of Dr. Tom Hamilton of Columbia City, distinguished himself by his letter to a Fort Wayne newspaper editor in which he deplores the report that Richard Nixon shouldn't be elected because he is an anticommunist. Steve asks—"Since when has it been that the leaders of a great democracy should be chosen because of their acceptability to a democracy's enemy, Communists?"

The eight-page inserts, of which there were three, employed as institutional advertising by the Pharmaceutical Manufacturers Association in the Reader's Digest proved to be the best read advertisements to ever appear in the Digest. A readership survey showed that 65% of those interviewed read at least one of the articles and 44% read all three. A fourth insert advertisement appeared last September and another series is planned for 1969.

Florida State University has a department of Urban and Regional Planning which will add several courses devoted to social planning management. The new courses will teach planners how to design cities that will better meet people's social and psychological needs. A grant from the National Institute of Mental Health will enable the expansion.

The Veterans Administration, which has performed approximately 350 kidney transplants, (about one-third of the transplants in the U. S.) reports that the operation is out of the realm of the spectacular now and that the survival rate is improving constantly. When a patient receives a kidney from a relative with the same blood type and tissue type, he has a 75 to 80% chance of living at least one year and 50 to 65% chance of living two years or more.

Following the liberalization of campus drinking rules in many colleges, the National Institute of Mental Health calls for alcohol education programs. The Center for Prevention and Control of Alcohol believes that such instruction is at least as important as health and sex education. Some colleges now conduct seminars for teacher preparation in the fields of sex, drug abuse and smoking, and should do the same for alcohol. ◄

New Zoning Ordinance Creates Hospital Districts*

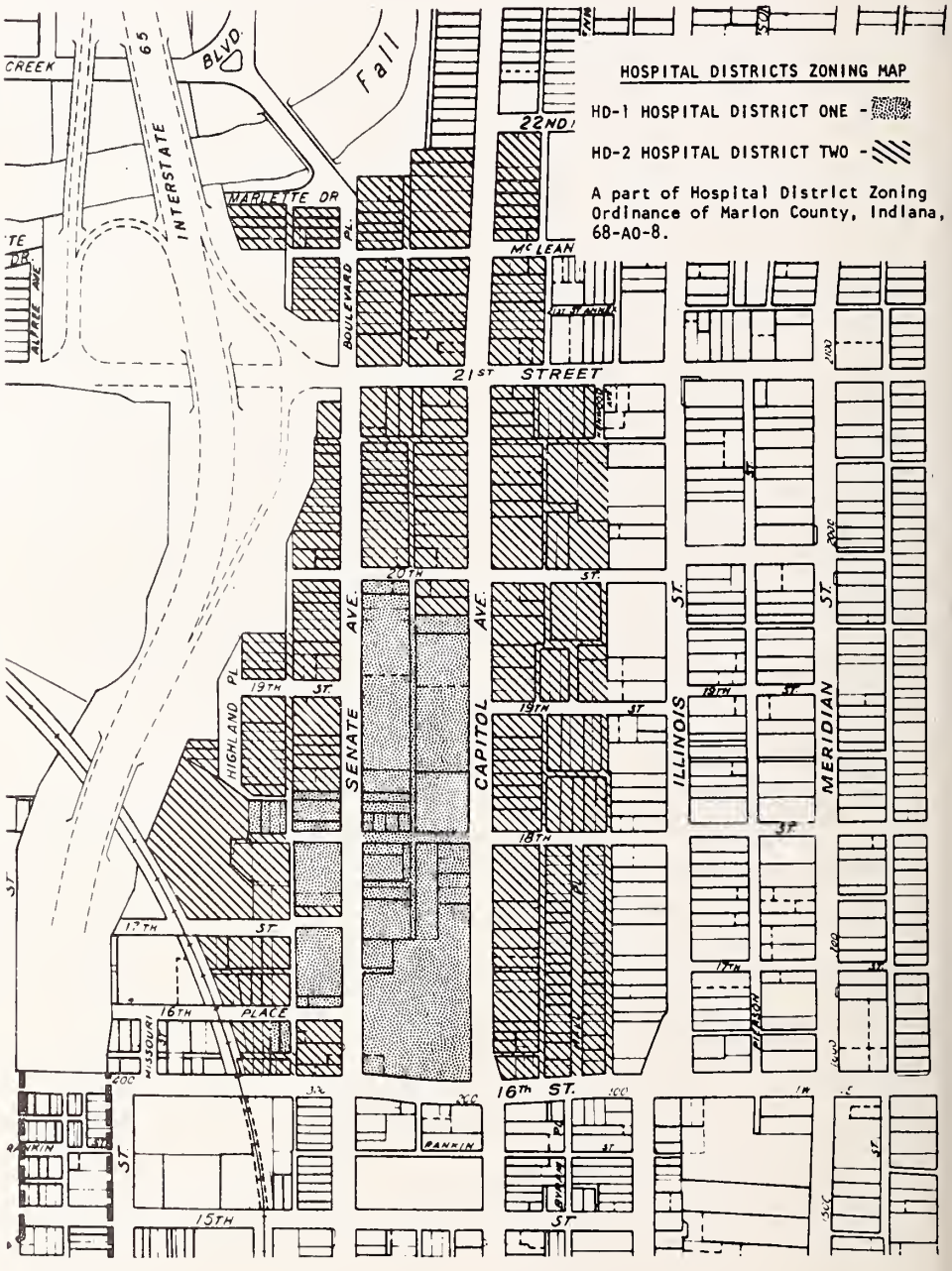
OPPORTUNITY for the future growth of the Methodist Hospital complex received a major assist recently when the Metropolitan Plan Commission, recognizing future land needs of hospitals and related services, passed a zoning ordinance which permits the establishment of hospital districts as part of the Comprehensive Plan for Marion County.

This achievement, which is believed to be the first of its kind in the nation, was a joint effort of the Metropolitan Plan Commission staff and Methodist Hospital administration. As such, the Methodist Hospital District is the first and only district recognized to date through the passage of the new ordinance. Similar opportunities now become available for other hospitals in the community.

In introducing the need for such zoning, the planning staff's statement indicates, "Besides relating to the metropolitan area as a whole, each hospital complex relates very strongly with a large segment of the community in which it is centered and to which it is most easily accessible. As one of the most basic of all functions within a given segment of the community and with a typically expanding physical plant and services, protection of existing facilities, assurance of land for future expansion and development of a proper environment are crucial to insuring the maximum possible medical service to the community."

HD-1 and HD-2, the two zoning districts assigned to Methodist Hospital, will be known as the Methodist Hospital Quarter.

HD-1 includes land owned by or now comprising the Methodist Hospital complex. HD-2 is an approximate 16-block area which will be restricted to land uses and functions related or oriented to the operation of Methodist Hospital.



The latter area will be reserved for physicians' office buildings, medical laboratories, surgical and medical supply firms, hospital equipment rental, nursing and convalescent homes, retirement homes, parking garages, dormitories, apartments and other residential structures, pharmacies, florist, card and gift shops and other similar uses.

HD-2 for related services includes land adjacent to the Methodist Hospital complex and bounded on the east by the alley west of Illinois Street, on the South by 16th Street, on the west by a railroad right-of-

* Reprinted with permission from the *Methodist Hospital Beacon*, October, 1968.

way and proposed Interstate 65 and on the north by Fall Creek at 22nd Street.

As part of the Metropolitan Planning Department's comprehensive plan for Marion County, land in the Methodist Hospital Quarter will also be subject to regulations to control setback of buildings, landscaping, off-street parking, use of signs and other aspects of land and architectural development. Regulations of this type will tend to create throughout the area an atmosphere compatible with the hospital complex. ◄

The editor and the staff of

The Journal wish you all

a Very Merry Christmas and

a Peaceful, Happy New Year

Merry Christmas

WANTED: Physicians Locations

GENERAL PRACTICE

William Buege, U.S.P.H.S. Hospital, 6500 Hampton Blvd., Norfolk, Va. 23508

David P. Lucchino, 26 Garden Place, Brooklyn, N.Y. 11201

Frederick T. Mansell, 6679 Apache Circle, Cincinnati, Ohio 45243

SPECIALISTS

George Hollo, Deer Lodge Hospital, Winnipeg, Manitoba, Canada—*Anesthesiology.*

Alan Guttman, 8891 Mockingbird Lane, Cincinnati, Ohio—*Ear, Nose & Throat.*

Choday Rama Mohan Rao, P.O. Box 276, Hines, Ill. 60141—*General surgery.*

Joseph P. Dineen, 412 Mix Ave., Hamden, Conn. 06514—*General surgery.*

Mohamad Taghi Rajabiun, 6 Sleepy Hollow Drive, Cumberland, Rhode Island 02864—*General surgery.*

Shannon Wilentz Turney, 1811 Castleman Drive, Nashville, Tenn.—*General surgery.*

Yilmaz C. Bilsel, 4045 Germania, St. Louis, Mo. 62116—*Internal medicine.*

Anthony M. Tanno, 1464 E. Queen Street, Annville, Penn. 17003—*Internal medicine.*

Stephen Graves, 11311 Shaker Blvd., Cleveland, Ohio 44104—*Internal medicine.*

Stanley Benjamin Wolfe, 4047 Gateway Court, Indianapolis, Ind. 46224—*Internal medicine.*

Keith C. Bogart, 4029 Lori Circle, Madison, Wis. 53714—*Neurology.*

Donald D. Colfield, 5905 Meadowwood Dr., Indianapolis, Ind. 46224—*Ophthalmology.*

John N. Hackett, 126 Willow Rd., Elmhurst, Ill. 60126—*Ophthalmology.*

Ziliha Bilsel, 4045 Germania, St., Louis, Mo. 63116—*Pediatrics.*

Gerald S. Freifield, 3363 Sedgwick Ave., Bronx, N.Y. 10463—*Neurosurgery.*

Larry Ray Lane, 11630 W. Gilbert Ave., Wauwatosa, Wis. 53226—*OB-GYN.*

John H. Stanley, 717 Giblin Ave., Iowa City, Iowa 52240—*Psychiatry.*

Nalin Shan, J.C.D. Hospital, 86 E. 48th St., Brooklyn, N. Y. 11203—*Pathology.*

Antun Lesica, 1120 Washington Blvd., Oak Park, Ill.—*Pathology.* ◄

in the treatment of
IMPOTENCE

Android®
(thyroid-androgen) TABLETS

*Effectiveness confirmed by another double blind study**

1. SUMMARY
ANDROID — GOOD TO EXCELLENT 75%
PLACEBO — 20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

*"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths

Android
Each yellow tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY
Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY
Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C
Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

also available with ESTROGEN
Android-E
Each Tablet Contains:
Methyl Testosterone ..... 2.5 mg.
Ethinyl Estradiol ..... 0.02 mg.
Thyroid Ext. (1/6 gr.) ..... 10 mg.
Thiamine Hydrochloride ..... 10 mg.
Glutamic Acid ..... 50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE:** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS:** In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRA-INDICATIONS:** See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

Write for literature and samples:
BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

REFER TO PDR

Are your P.D.A.

(Past Due Accounts)

stubborn as a mule?

Let the **Associated Credit Bureau** member in your area pull your P.D.A. (Past Due Accounts) back in the black. Thirty years of experience PLUS the listing of delinquent accounts on the individual's master credit record in the Credit Bureau produce successful collections. *No other* collection firm can offer you this unique method of collecting your P.D.A. (Past Due Accounts).

TO GET MOVING ON YOUR P.D.A.
CALL US TODAY!

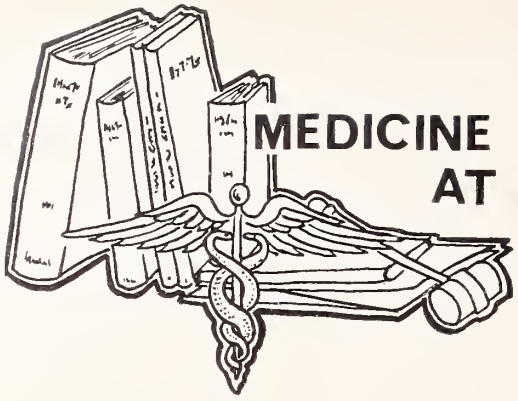
Associated Credit Bureaus

OF INDIANA

affiliated with

ASSOCIATED CREDIT BUREAUS OF AMERICA

Contact your local ASSOCIATED CREDIT BUREAU OF INDIANA *member*



Party Seeking Examination Entitled to Choose Physician—In an automobile injury suit for damages, the injured person should have been required to submit to a pretrial examination by the physician selected by the allegedly negligent driver, the Minnesota Supreme Court ruled. Personal hostility between the injured person's attorney and the selected physician did not justify the trial court's refusal to require the examination.

The injured person sustained nerve and brain damage in the accident. A rule of civil procedure provides that where a party's physical or mental condition is in controversy, the trial court may order him to submit to an examination. The allegedly negligent driver requested an order requiring the injured person to submit to an examination by a named physician. No objection was raised to submitting to an examination, but the injured person's attorney objected to having the examination performed by the named physician. The attorney said that a personality conflict existed between him and the physician as the result of the physician's appearance as an expert medical witness in a previous personal injury action. The trial court held that the party requesting the examination does not have the right to select the physician, especially when the other party objects.

The refusal to require the injured person to submit to an examination by the physician named was an abuse of discretion, the reviewing court said. A party may not, by an unreasonable objection to the physician chosen by his opponent, thwart the rule under which the request was made. The objection based on the personality conflict between the injured person's attorney and the physician was an unreasonable one.—*Wasmund v. Nunamaker*, 151 N.W.2d 577 (Minn., June 6, 1967).

Testimony in Suits Involving Specialized Knowledge—A medical secretary was entitled to recover under the disability income provision of her insurance policy. The trial court's finding that she was unable to perform her duties was supported by her testimony and that of her attending physician, the New Mexico Supreme Court ruled.

In an automobile accident, the secretary had sustained several fractured ribs, fractures of transverse processes of a number of vertebrae, multiple contusions and cervical neck strain. An orthopedist who testified for the insurer stated that her injuries should have healed completely in four to six months and that his examination had disclosed no condition that would prevent her from performing her duties.

The secretary and her attending physician testified that back and leg aches, sciatica and neuritis pains from which she suffered as a result of the accident were such that she was unable to perform her duties. The fact that the attending physician was a general practitioner with less experience at reading x-rays than the orthopedist did not require that his testimony be disregarded. It was for the trial court to weigh the evidence and pass on the credibility of the witnesses.—*Sawyer v. Washington National Insurance Company*, 429 P.2d 901 (N.M., July 10, 1967).

Autopsy Report Inadmissible—A widow who tried to introduce a pathologist's written autopsy report as evidence at a trial in order to show that her husband's death was caused by his employment was denied Workmen's Compensation death benefits. The pathologist did not testify in person, and his qualifications as a medical expert were not shown. The Tennessee Supreme Court excluded the report as being hearsay and as being prejudicial against the employer, who could not cross-examine the physician. No other evidence was available to show that the death was connected with the work.

The document was not admissible under the Business Records as Evidence Act, which provides that a record can be used if a qualified witness explains what it means and how it was prepared and if the court believes that the sources of information and the method of preparation justify including the record in evidence. The widow was not a qualified witness who could speak with authority about the autopsy report.

Two years before death, the husband was awarded Workmen's Compensation benefits after he became dizzy, nauseous and emotionally upset as a result of inhaling exhaust fumes while working with a gasoline-powered motor vehicle. When he died, the widow filed her petition for death benefits.

At the trial, the widow presented the autopsy report, which stated that the cause of death was "probable chronic peptic ulcer." Another physician testified that the most common cause of stomach ulcers was excessive hydrochloric acid and that nervousness could cause excessive production of the acid. The physician said he

did not know the cause of death.

The widow attempted to show that the ulcer was affected by emotional distress resulting from the original accident at work. The court ruled in favor of the widow. However, since the reviewing court held the autopsy report inadmissible, the widow had no way to prove that the death resulted from the employment, and the judgment was reversed.—*Neas v. Snapp*, 426 S.W.2d 498 (Tenn., March 27, 1968).

Blood Test by Medical Examiner Admissible—A report by a physician who took a blood sample from a man killed in an automobile collision was properly admitted as evidence to show that the man was intoxicated while driving, ruled an Iowa appellate court. After the accident, the man was taken to a hospital, and he was pronounced dead by the physician, who was a county medical examiner. On his own initiative, the physician took a blood sample. He wrote a report stating that shortly after death the man had 344 milligrams of alcohol per 100 cc of blood.

In a suit by the father of the deceased against the other driver to recover damages for the death, the father claimed the report should be excluded because it was privileged communication. The court ruled that the report was admissible because the physician was acting within his official role as examiner when he took the sample. Under Iowa law, reports by the examiner are not privileged and can be used as evidence in court.

The father charged that taking the blood constituted an illegal search and seizure. He alleged that the methods used violated the Iowa Implied Consent Law. This statute provides that a person reasonably suspected of drunken driving impliedly consents to allow the medical examiner to take a blood test when a police officer, in writing, requests the examiner to do so. The statute did not, however, preclude the physician from taking a sample without being asked by an officer to do so, ruled the court. The father's charge that the physician had exceeded his authority as examiner in withdrawing the blood on his own initiative was, therefore, groundless. The court also said that there was no illegal search and seizure because the consent implied by law still existed, even though the person was dead, and it was not necessary to obtain a search warrant.—*Jacobsen v. International Transport, Inc.*, 391 F.2d 49 (Iowa, March 19, 1968).

"Sudden Emergency" Not Established In Foreign Body Case—A patient in whose abdomen a hemostat was left during surgery to correct an esophageal hernia won a damage award of $24,500. The two surgeons who performed the operation pleaded that a "sudden emergency" which required them to perform a splenectomy during the surgery caused them to forget the hemostat. In affirming the award, the Supreme Court of Mississippi said that it was not so large as to indicate bias, passion, or prejudice on the part of the jury.

From the time of the operation, the patient complained of pain in his side, especially when he moved or changed position. X-rays taken three weeks after the operation disclosed a scissors-shaped tonsil hemostat, made of stainless steel and about eight inches long, in his abdomen. The two surgeons who performed the hernia operation performed a second operation and removed the hemostat. The patient was unable to return to full-time work for six months.

The surgeons contended that they could not be held liable because they had been confronted, during the operation, with the sudden emergency of having to perform the splenectomy. They said that this caused them to leave the hemostat in the patient's body.

The surgeon's evidence was as follows: when the incision was made, the patient was found to have a sliding esophageal hernia, which made necessary the pulling of the stomach from the chest into the abdomen so that the hernia could be repaired; while tying the lower end of a blood vessel in the process of dissecting the hernia, one of the surgeons noticed very brisk bleeding coming from the location of the spleen; he considered this an emergency and dropped what he was doing and examined the spleen; when the spleen was found to be the source of the bleeding, it was removed; the hernia operation was continued after the spleen was removed.

The chief surgeon testified that the hemostat, with which he was clamping the blood vessel when the bleeding from the spleen was discovered, was evidently pushed aside, out of his field of view, during the splenectomy, and that he forgot about it. He said that he made a physical exploration of the patient's abdomen before closing the incision. He stated that it was the general practice to count sponges, but not hemostats, during an operation.

The court said that there was serious doubt whether the "sudden emergency" doctrine was applicable. The emergency was the rupture of the spleen, which was inadvertently caused by the pulling down of the stomach. Apparently, this might reasonably have been foreseen. In any event, the alleged emergency existed for only the relatively short time that it took to remove the spleen. The only effect of the emergency was to divert the chief surgeon's attention from what he was doing and to cause the hemostat to be pushed out of his sight, after which he forgot it and what he had been doing. His failure to remember constituted negligence.

Further, if he had made a thorough exploration of the patient's abdomen before he closed the incision, he should have discovered an object as large as the hemostat in question. Although there have been

cases in which failure to make a thorough exploration before closing an incision has been held justified because the patient's life was being jeopardized by the operation, no such emergency existed here.

The surgeons contended that, since the patient's medical expenses and loss of earnings resulting from the second operation were, at most, $7,000, the verdict was so excessive as to show bias, passion, and prejudice on the jury's part. However, since the patient did have some pain and suffered the anxieties incident to major surgery, the verdict was not excessive, the court said.—*Long v. Sledge*, 209 So.2d 814 (Miss., April 29, 1968).

Circumstantial Evidence Sufficient In Foreign Body Case— Even without expert testimony, circumstantial evidence was sufficient to raise a question for the jury as to whether a physician left a needle in a patient's body while performing an episiotomy and whether it was the cause of the pain of which she complained. When the jury was unable to reach a verdict, the physician was not entitled to have the court enter judgment in his favor, the Connecticut Supreme Court ruled.

Episiotomies were performed in connection with the births, in 1951 and 1956, of the patient's first two children. She experienced no pain or discomfort in the perineal area after the birth of either child. The patient first consulted the physician in September, 1958, when she was pregnant with her third child. She experienced no pain during his initial internal examination of her or at any other visit to him prior to the delivery of her third child.

The physician, in delivering the patient's third child, performed an episiotomy, in which he made an incision mediolaterally and followed the episiotomy scar from the two previous deliveries. In repairing the episiotomy, the physician used a curved suture needle.

Immediately after the delivery of the third child, the patient began to complain of pain in the perineal area. She continued to complain of intense jagged, sharp pain in the area and consulted a number of physicians. Fifteen months after the delivery, the patient consulted her family physician about a hard object in her thigh. He removed from her inner right thigh, about two inches from the vagina, a suture needle of the type used by the physician in repairing the third episiotomy. The patient thereafter suffered no pain in the perineal area.

The physician contended that he could not be held liable because there was no expert testimony establishing how long the needle was in the patient's body. He argued that lay persons were not qualified to determine whether a needle was the cause of her pain, since the needle was not found until 15 months after the episiotomy. The court ruled that this question was for the jury and that the jury's determination could be based on circumstantial evidence. A jury could find that the physician had left the needle in her body and that it was the cause of her pain from the facts that she had suffered no pain from two previous episiotomies, had complained of pain immediately after the third episiotomy, and had continued to complain of such pain until the suture needle was removed 15 months after the third episiotomy.

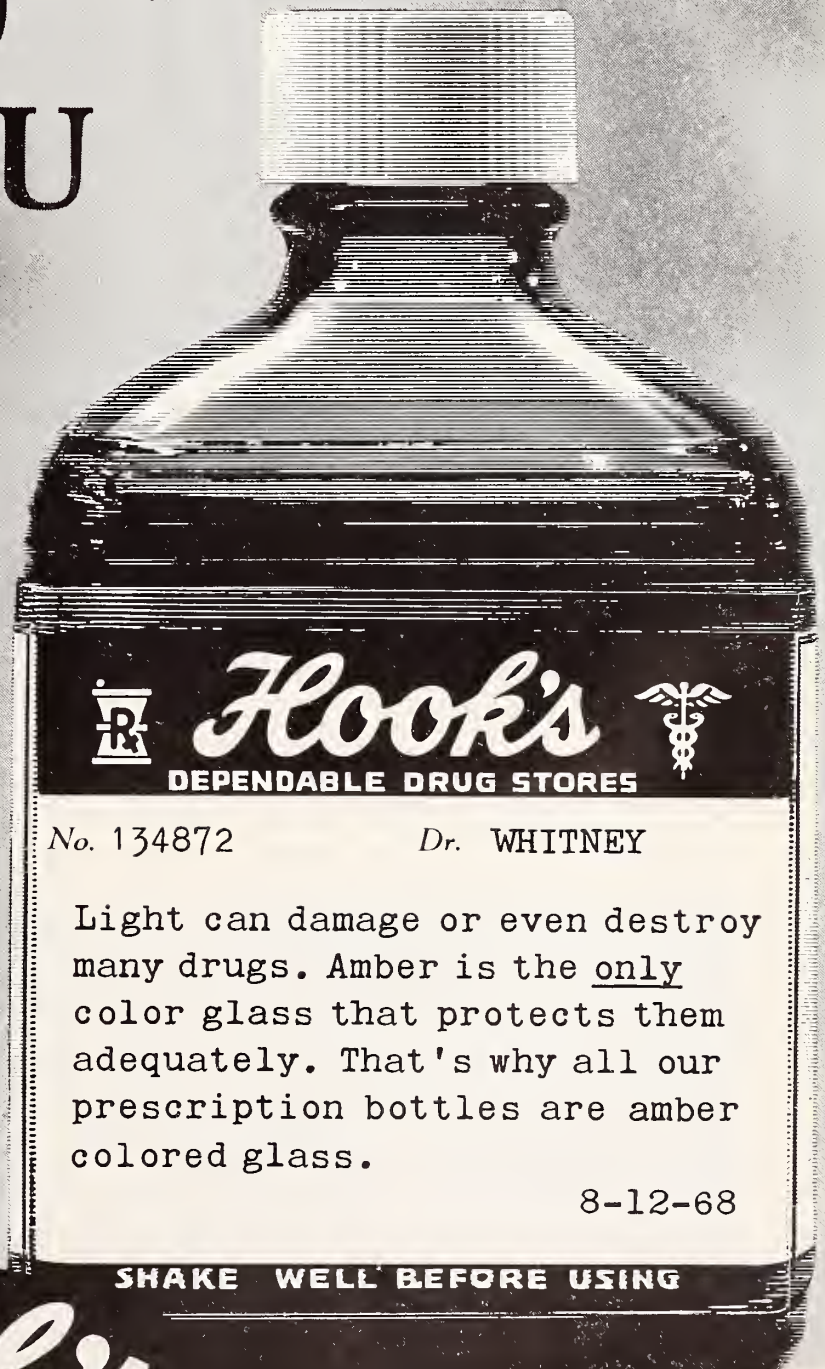
The applicable standard of care was established by the physician's own testimony that it would not be in accordance with accepted standards of practice in the community to leave a suture needle in a patient's body in the course of repairing an episiotomy.—*Console v. Nickou*, 240 A.2d 895 (Conn., March 20, 1968).

Skill In Injection Presumed Despite Nerve Damage—In a patient's suit for professional negligence against a medical partnership and a nurse employed by it, there was a presumption that they had used medical skill. The patient allegedly suffered sciatic nerve injury as the result of the nurse's negligent administration of an injection in his gluteus maximus muscle. Judgment in favor of the partnership and the nurse, entered on the trial court's verdict, was affirmed by a Georgia appellate court.

The court rejected the patient's contention that instructions given to the jury in the trial court—that there was a presumption in malpractice cases that medical service was performed in a skillful manner, and that a physician cannot be held liable if he uses reasonable care in the application of his skill—were improper.

The court said that the charges were correct principles of law, whether the negligence charged to physicians was their own or that of their employees under the doctrine of *respondeat superior*. Moreover, the trial court did, later in his charge, instruct the jury that the partnership was under the doctrine of *respondeat superior*, liable for any negligence on the part of its employees. The jury could reasonably have concluded, under the charge as a whole, that the negligence, if any, of the partnership must be based solely on the doctrine of *respondeat superior*.—*McKinney v. Schaefer*, 161 S.E.2d 446 (Ga., April 3, 1968). ◀

What's Good for Your PRESCRIPTION is GOOD FOR YOU



Hook's
DEPENDABLE DRUG STORES

Hook's extra care and low prices may account for the ever growing number of our prescription customers. We believe so! We were trusted over 2½ million times last year; we invite you to compare and save.

Blue Shield Report to ISMA House of Delegates

(One of a series prepared by Blue Shield)

(Following is the report to the House of Delegates of the Indiana State Medical Association made in October, 1968, by Glen V. Ryan, M.D., Chairman of the Blue Shield Board of Directors.)

1967 for Indiana Blue Shield was a year of continued growth . . . a year of complex new problems to be solved . . . a year of reorganization.

We made a net gain in membership of more than 100,000 during 1967, and with additional increases in 1968, our membership has now passed the 1,800,000 mark. Add in the more than 200,000 in the state who are eligible for Medicare and are not Blue Shield members and you'll find that we are now serving more than two million individuals. During the past five years, regular Blue Shield membership has increased from 1,500,000, to 1,800,000—a net gain of almost 20%.

During 1967 we paid out $34,699,878 for physicians' services —the largest amount ever paid in one year. Since 1946, the year the Indiana Plan was organized, we have paid on behalf of our members to physicians more than $276,000,000.

Membership increases and new and broader benefits mean more claims, and during the year we paid almost one million claims—by far the most we've ever paid in one year.

Despite necessary increases in personnel and equipment to meet our increased workload, efficient administration during this year of growth held our operating cost ratio to only 6.8% of each income dollar.

During 1967 many of the problems and delays that were a part of the first six months of Medicare were resolved, and working routines were established successfully for most phases of claim processing. During the year our Medicare Department processed for payment more than 440,000 claims. The total amount involved in Part B payment was more than $19,000,000. Presently we are processing nearly 2,800 claims a day. Routine claims are being paid in an average of 14 working days. The average for all claims—including problem claims is 19 days.

Included in our membership totals are almost 180,000 persons 65 and over who are protected by our Medicare supplement benefit program. This type of membership showed a 9,000 increase for the year.

In 1967 our program of selling broader benefit plans to new accounts and converting present accounts to higher coverage continued to show substantial gains.

At the end of the year, a total of over 1,300,000 members were enrolled under the preferred or special surgical programs, and a similar number were covered under diagnostic x-ray and pathology benefit protection. Members protected by our preferred or special in-hospital medical program totaled 1,090,000.

One of the major accomplishments during the year was the development and growth of new and broader benefit programs. New benefits initiated during 1967 included outpatient psychiatric care and pre- and postnatal care. Much was also accomplished in the development of our prescription drugs and dental programs.

Indiana Blue Shield's "usual and customary" approach to paying physician fees is referred to as the "local county program." This term, "local county program," originated with the passage of Resolution No. 26 by the Indiana State Medical Association. In general, this resolution resolved that Blue Shield be encouraged to market a program which would have no schedule of dollar allowances. It also resolved that county societies or regional groups of counties shall establish review committees responsible for reviewing, when necessary, unusual services or charges in light of the "going rate" concept for that locality.

The "local county program" is planned so that Blue Shield members should receive no additional charge above the usual and customary fee unless the doctor advises the patient of an additional charge prior to rendering his service. This approach supports the principles of free enterprise and the physician's right to contract for any fee he feels is appropriate.

A large part of the success of Blue Shield's usual and customary program depends on the understanding and cooperation of the individual physician and the state and county medical societies.

Blue Shield benefits for many accounts were upgraded to "local county programs," and presently over 50% of all Blue Shield group memberships now include usual and customary charge provisions.

During the year Major Medical coverage increased by more than two hundred thousand persons, and at this time more than four hundred thousand of our members have added Major Medical coverage to their benefits. We paid more than 9,000 Major Medical claims during the year, to account and direct pay and Medicare supplement members, as well as participants in the Federal Employees program.

Using the theme "Mapping the World of the Future" as a guide, some 350 Blue Shield Advisory Council doctors and their wives attended a two-day seminar held in Indianapolis in April of this year. The featured speaker was Dr. Milford O. Rouse, president of the American Medical Association, who spoke on "The AMA and Blue Shield—A Common Purpose and Concern." Dr.

Rouse urged an even closer relationship be developed between Blue Shield and organized medicine as they seek to solve common problems in the delivery of health care benefits to the citizens of Indiana.

Other challenges to Blue Shield and the medical profession were presented by Lowell H. Steen, M.D., chairman of the Council, Indiana State Medical Association; Mr. Victor M. Zink, General Motors Corporation; and Mr. William Ryan, vice president of the National Association of Blue Shield Plans.

Once again this year our Professional Relations Department conducted a series of dinner-workshops for the medical assistants throughout the state. The attendance at these informative and popular meetings totaled over 3,500. These workshops provided an opportunity for the doctors' assistants to gain an insight into many of the new Blue Shield benefit programs.

We also this year conducted a series of dinner-workshops for interns and residents planning to practice in Indiana in an attempt to help this young group gain a better insight into the economics of the practice of medicine. Over 150 interns and residents and their wives were present at these sessions.

It was our privilege to continue in 1968 our close relationship with members of the Woman's Auxiliary to the Indiana State Medical Association by informing them of the new developments in Blue Shield and assisting them in the preparation for their state convention.

In 1967, Blue Shield's membership nationwide surged from 60.0 million to 62.5 million. At the same time the individuals served by Blue Shield under government programs—such as Medicare and Title 19—increased from 11.5 to 11.8 million. Today Blue Shield serves some 74 million persons, and is indeed a significant force in health care financing.

Benefits paid under regular business last year were $1.5 billion, and Blue Shield Plans serving under government programs disbursed another $1 billion.

Operating expense increased a fraction of one percent during 1967. The combined operating expense of the 82 Blue Shield Plans averaged 9.3%.

A significant and increasing trend at Blue Shield has been the implementation of programs based on usual and customary fees. Currently 59 U.S. Blue Shield Plans are participating in some program of this type, involving nearly six million persons.

In concluding this report I would like to repeat a recent statement by Dr. Carl R. Ackerman, chairman of the board of directors of the National Association of Blue Shield Plans:

"Because of its major role in the financing of health care, Blue Shield has influenced the medical-economic environment, has itself been altered by outside forces, and faces a future which is at once promising and troubling. Medicine's involvement in Blue Shield is more appropriate—more necessary—than ever before. We in the medical profession and in Blue Shield are committed to a joint purpose of working together to see that quality health care, in a climate of free choice, is within the pocketbook of the vast majority of the people." ◄

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT — October, 1968

Disease	Oct. 1968	Sept. 1968	Aug. 1968	Oct. 1967	Oct. 1966
Animal Bites	687	900	1177	760	753
Chickenpox	130	49	50	91	92
Conjunctivitis	54	97	94	42	65
Diphtheria	0	0	0	1	0
Dysentery, Unspecified	23	19	50	33	62
Gonorrhea	497	555	640	398	421
Impetigo	183	247	211	204	188
Infectious Hepatitis	33	29	49	63	35
Infectious Mononucleosis	82	46	31	53	72
Influenza	890	701	191	777	509
Measles					
Rubeola	15	8	40	24	47
Rubella	64	36	58	21	24
Meningitis, Meningococcal	1	6	3	1	3
Meningitis, Other	1	2	5	3	3
Mumps	105	76	78	65	109
Pertussis (whooping cough)	13	21	28	24	6
Pneumonia	189	101	90	153	146
Poliomyelitis	0	0	0	0	0
Streptococcal Infections	368	331	438	446	348
Syphilis					
Primary & Secondary	32	29	35	29	6
All Other Syphilis	117	121	145	51	52
Tinea Capitis	9	13	6	2	13
Tuberculosis (Active)	80	83	61	65	98

"COCA-COLA" AND "COKE" ARE REGISTERED TRADE-MARKS WHICH IDENTIFY ONLY THE PRODUCT OF THE COCA-COLA COMPANY

FUTURE MEETINGS, SEMINARS, COURSES

National Conference on Breast Cancer Set for Washington in May

The National Conference on Breast Cancer will be held in Washington, D. C., at the Shoreham Hotel, on May 8, 9 and 10, 1969.

Members of the medical profession are invited to attend. There is no registration fee. Preregistration in requested. For information write to Dr. Roald N. Grant, American Cancer Society. 219 E. 42nd St., New York City 10017.

1969 American Industrial Health Conference Will be Held in Houston

The 1969 American Industrial Health Conference will be held April 21 to 24, 1969, at the Shamrock Hilton in Houston.

The Industrial Medical Association and the American Association of Industrial Nurses will conduct a medical-nursing conference. Address the Conference at 55 E. Washington St., Chicago 60602.

The Cleveland Clinic Announces Postgraduate Continuation Course

The Cleveland Clinic announces a postgraduate continuation course in "Surgical Problems of the Liver, Biliary System, Pancreas and Spleen", on January 15 and 16, 1969.

Write the Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland 44106 for further information.

33rd Annual Session of the International Medical Assembly

The 33rd Annual Session of the International Medical Assembly of Southwest Texas will be held in San Antonio, Texas, January 27, 28, and 29, 1969 at San Antonio's new convention center. There will be 18 guest speakers representing various specialties.

In addition to the scientific program there will be social events, golf, tennis and skeet. A post convention trip to Guadalajara and Puerto Vallarta is planned. Write Dr. Joaquin B. Gonzalez, 202 W. French Place, San Antonio 78212.

"Diagnosis and Management of Respiratory Insufficiency" Course

"Diagnosis and Management of Respiratory Insufficiency" is the title of a course being offered by the University of Chicago Hospitals on February 12, 1969.

The conferences are given by members of the various departments of the University of Chicago. For further information and registration forms, write: Frontiers of Medicine, The University of Chicago, 950 E. 59th St., Chicago, Ill. 60637.

University of Colorado Offers Postgraduate Hand Surgery Course

The University of Colorado will conduct a postgraduate course in "Surgery of the Hand" February 17-20, 1969.

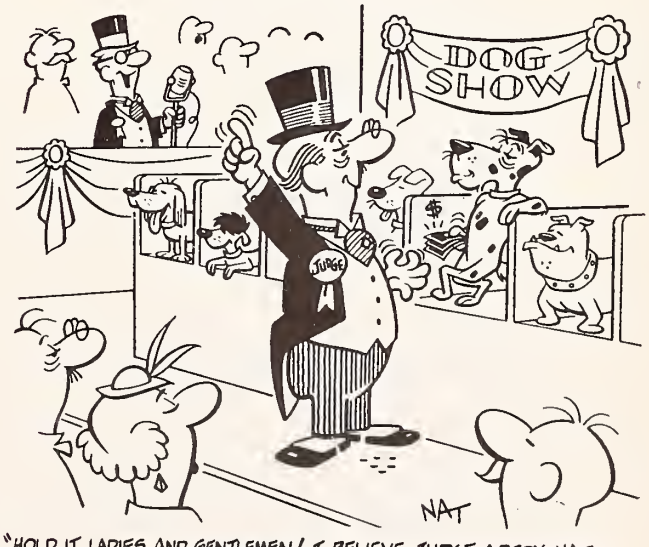
The program will be presented by both the Colorado faculty and guest speakers. Registration and tuition fees and further information on the course may be obtained by writing Postgraduate Medical Education, 4200 E. Ninth Ave., Denver 80220.

Postgraduate Continuation Course In Gastroenterology Offered at Phoenix

The Institute of Gastroenterology, Good Samaritan Hospital, and the Veterans Administration Hospital in Phoenix are co-sponsoring a postgraduate continuation course in gastroenterology in Phoenix. The course will be held at the Del Webb Towne House on February 21 and 22, 1969.

The purpose of this course will be to relate current physiological knowledge and newer diagnostic technics to clinical gastroenterology with particular attention toward the therapy of the disease. Faculties include J. Edward Berk, Henry L. Bockus, Robert J. Bolt, Thomas C. Chalmers, J. Lynwood Herrington, Nicholas Hightower, Hans Popper, Fenton Schaffner, Kenneth W. Warren and others.

Further information and registration forms may be obtained from Dr. David C. H. Sun, Good Samaritan Hospital, Phoenix, Arizona 85002. ◄



"HOLD IT, LADIES AND GENTLEMEN! I BELIEVE JUDGE ADCOX HAS FINALLY FOUND A WINNER !... "

ABSTRACTS, BOOK REVIEWS

ORGANIZATION AND MANAGEMENT OF FAMILY PRACTICE

Committee on Medical Economics of the American Academy of General Practice, American Academy of General Practice, Volker Boulevard at Brookside, Kansas City, Missouri, 1968.

This is a softbound book of 105 large-sized pages. It is divided into three parts.

Part one describes the new speciality of family practice: how it differs from other specialties, how it meets public demand, how it evolved and how its specialists must be trained to meet advancing standards. It describes family practice as a comprehensive and continuing type of care and then delineates family practice in the care content of family medicine. Read this section if you are interested in the concept of a new specialty or if you are interested in the ambiguous periphery of family practice which seems to overlap other specialties.

Part two abruptly shifts the tone from "this is how it should be" to "this is how it is, baby!" If you are just starting a new practice or wish to evaluate an old practice read this section on types of practice, practice locations, office layouts, equipment, office assistants, office procedures, office policies, diagnostic procedures, insurance and personal financial planning. Some forms are demonstrated in this section. This section shows more organization, facts, and succinctness than have similar books. For instance it lists the relative probabilities of death versus prolonged disability by decades of age—helpful in deciding how much life versus how much disability insurance to buy.

Section three describes how to find and use various community resources usually available. It also describes AAGP and AMA national and local and tells how to use their services.

This book has been furnished free to some physicians and students. Others may purchase it for $1.00 from the AAGP at the Kansas City address.

ALVIN J. HALEY, M.D.
Fort Wayne

FAMILIAR MEDICAL QUOTATIONS

Edited by Maurice B. Strauss, M.D., Little Brown & Co., Boston, 1968; 968 pages; $15.00.

The advance fliers were so well prepared that I anticipated the book itself most eagerly. Maybe, the build-up was too great: frankly, I found the perusal of its contents somewhat disappointing. Some of the stuff was rather insipid; some of the quotes I looked for, just were missing. Still, all that is a matter of personal taste and preference; I'm sure that the editors will be hearing from the readers and the NEXT edition will be greatly improved.

I *do* find some gross errors: not only typographical but also just sheer oversight! Just as an extreme example, I find on page 513, under "Rheumatic Fever", a quote from "Jean Bouil*ldu*." A moment's reflection told me that "Jean Baptiste Bouil*laud*" was the man in question as the eponym for rheumatic fever carries this eminent clinician's name. Well, so this is a bad typographical error. Then, I looked in the index: again, carefully listed as "Bouil*ldu*" . . . . So: this is *not* a mere typographical error but just sheer ignorance—on whose part? At which member of the most eminent editorial board do I point an accusing finger?

For all my carping critique, the volume is beautifully printed on good paper; the type is clear and the binding excellent. I'm sure that the NEXT edition will be clear of barbarisms and solecisms; it will grace ever more shelves of ever more libraries, both public and private.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

COMMUNICATION IN SCIENCE

Ciba Foundation Symposium, edited by Anthony de Reuck and Julie Knight, Little Brown & Co., Boston, Mass., 1967; 274 pages with numerous tables and figures; $12.50.

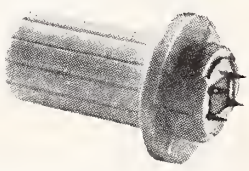
The logarithmic growth of world literature is continuing unabated. Documentation requires automation. The computer is alerting intercourse between scientists almost as radically as printing did with the handwritten letters that preceded Gutenberg.

The two dozen assembled experts are using a jargon all their own. I'm glad to know that the presently used score of a thousand computers will become quintupled by 1984. I'm sure you've heard of computer "hardware" and "software" but: have you been told anything anent "liveware"? Well, that is the word for "human intelligence." (Why the quotation marks?)

Speaking of new termins: success is predicted for "taxonomicisable" data banks "which are the chief problem for the technologist." Happy day! Is this what makes science hard but leaves parts of Nauka and Wissenschaft soft?

Dr. D. J. deS. Price of Yale makes a very excellent attempt

Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?
or
HISTO?
(Histoplasmosis—"The Masquerader")



A new aid in differential diagnosis
HISTOPLASMIN, TINE TEST
(Rosenthal)
The LEDERTINE™ Applicator with the Blue Handle

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle

Ask your representative for details or write Medical Advisory Dept., Lederle Laboratories, Pearl River, New York 10965. 406-8

at trying to make sense of the new information technologies. For my part, I was able to comprehend more when I listened for half an hour to a talk by Dr. Cesar Caceres on "Computers in Cardiology."

Hospital and medical school libraries will acquire this symposium for their shelves. The binding, printing and paper are (as usual) impeccable. The expected audience will be very select, very small—and most competent.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

Abstracts From Various Literature, Prepared by AMA

MALIGNANT TUMORS AS LATE COMPLICATIONS OF VACCINATION

W. B. Reed and E. W. Jones (Institute of Dermatology, St. John's Hospital, London)

Arch. Derm. 98:132-135, (Aug.), 1968.

Four examples of basal cell epitheliomas and a malignant melanoma, which arose in vaccination scars of middle aged and elderly patients, are described. In addition, a 29-year-old patient with xeroderma pigmentosa developed a squamous cell epithelioma in a vaccination scar. The significance of these observations is discussed. All the patients lived in Southern California and most of them were fair-skinned and showed evidence of actinic damage to the exposed areas. Sun exposure on a previously scarred area may be the main factor in the etiology of the tumors. In the case of the malignant melanoma the tumor developed only nine months after vaccination and the possibility of a virus-induced mutation of melanocytes is mentioned.

MAJOR SURGERY IN PATIENTS ON MAINTENANCE HEMODIALYSIS

C. L. Hampers et al. (Peter Bent Brigham Hospital, Boston)

Amer. J. Surg. 115:747-754, (June), 1968.

The hospital records of 33 patients with chronic renal failure undergoing 44 major operations and requiring pre- and postoperative hemodialysis were reviewed. Dialysis was performed within 24 hours prior to surgery in 30 instances. Halothane was the general anesthetic most commonly used in conjunction with nitrous oxide. Except for two instances of cardiac arrest (one death) there were few intraoperative problems. All postoperative complications were minor and most patients demonstrated excellent wound healing. Twenty-three patients had dialysis within 24 hours of surgery. The most common indication for dialysis was a rapidly rising serum potassium level. The authors recommend that dialytic treatment should be carried out on the day prior to surgery; that there should be adequate control of hypertension, either by ultrafiltration or antihypertensive medication; and that serum potassium concentration should be below 5.5 mEq/liter on the day of surgery.

CHILDREN EXPOSED IN UTERO TO PROPYLTHIOURACIL: SUBSEQUENT INTELLECTUAL AND PHYSICAL DEVELOPMENT

D. N. Burrow et al. (333 Cedar St., New Haven, Conn.)

Amer. J. Dis. Child. 16:161-165, (Aug.), 1968.

In an effort to answer the question as to whether propylthiouracil (PTU) therapy in the pregnant thyrotoxic patient has harm-

Continued

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available

Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.

Assistant Professor of Psychiatry and Medical Director

Area Code 704-253-2761

Continued

ful effects on the subsequent intellectual and physical development of offspring, children who had been exposed to PTU in utero were compared to nonexposed siblings. Psychological testing did not reveal any marked differences between the two groups in either overall intellectual level or patterning of various mental skills. Nor did differences occur with respect to physical development or laboratory values, including thyroid function tests. Three children who were goitrous at birth were of special interest but did not differ significantly with respect to intellectual function, height, weight or bone age. Although the sample size was small, the data did not suggest that PTU therapy during pregnancy had an adverse effect on subsequent growth and development of a child in utero or postnatally.

INFLUENCE OF COFFEE ON METABOLISM OF FAT

W. Zeller (Clinic of Medicine, University of Erlangen-Nurnberg, Germany)

Med. Klin. 63:707-709, (May 3), 1968.

After 44 patients with various liver diseases and 41 healthy control individuals were fed a diet with the same percentage of fat, some of them were placed on additional coffee with a normal amount of caffeine in it; the other half were given decaffeinated coffee. Daily investigation of serum lipids demonstrated that mobilization of the free fatty acids depended directly on the absolute caffeine content in the coffee, not upon the way the coffee was prepared. Decaffeinated coffee did not upset the metabolism of fat at all. The author concludes that patients with liver diseases should not be given regular coffee containing caffeine.

SUDDEN UNEXPECTED DEATH IN INFANCY SYNDROME

E. B. Shaw (University of California School of Medicine, San Francisco)

Amer. J. Dis. Child. 116:115-119, (Aug.), 1968.

Nasal obstruction due to mild infection may well be the trigger for apnea and asphyxia in the sudden death syndrome in infancy. This hypothesis is based on the well known reluctance of infants to breathe through their mouths. Choanal atresia is a recognized cause of neonatal death. Some babies appear to be almost completely unable to adopt oral respiration and this may persist up to five or six months of age. These unexpected deaths almost always occur at night when the infant is unobserved and asleep; the postmortem evidence of infection can account for a collection of nasal secretion. The records of 28 infants (among 19,000 live births) who died with the SUD syndrome and who had carefully recorded "well baby visits" were reviewed and failed to indicate any physical or immunological defect, allergy or injury sufficient to account for this terminal event. All deaths occurred at less than six months of age.

MENTAL SYMPTOMS AS AN AID IN EARLY DIAGNOSIS OF CARCINOMA OF THE PANCREAS

I. Fras, E. M. Litin, and L. G. Bartholomew (Mayo Clinic, Rochester, Minn.)

Gastroenterology 55:191-198, (Aug.), 1968.

The incidence, character, and differential diagnosis of the mental symptoms associated with carcinoma of the pancreas are

presented on the basis of a study at the Mayo Clinic of 46 patients with this diagnosis and 79 control patients. These mental symptoms (i.e., depression, anxiety, and feeling of premonition of serious illness with several specific features) are frequent and can be used as an aid in the early diagnosis of carcinoma of the pancreas. Careful history taking and awareness of the specific aspects of the mental symptoms in carcinoma of the pancreas are necessary to distinguish carcinoma of the pancreas from certain psychiatric problems.

MEAL FREQUENCY AND ISCHEMIC HEART DISEASE

P. Fabry et al. (Institute for Cardiovascular Research, Prague)
Lancet 2:190-191, (July 27), 1968.

Grouping of 1,133 men, aged 60 to 64, was conducted according to the frequency of food intake. Ischemic heart disease was significantly more common among those who took three meals per day (or less) than among those who took five meals (or more). Men consuming three to four meals had intermediate prevalence figures.

OCCURRENCE OF ECTOPIC PREGNANCY IN WOMEN WITH IUD'S AND CONSIDERATION OF CONTRACEPTIVE MECHANISM OF IUD

P. Y. Wei (National Taiwan University Medical College, Taipei, Taiwan)
Amer. J. Obstet. Gynec. 101:776-778, (July 15), 1968.

In 5½ years (1962 to 1967) 35 patients with intrauterine devices (IUD) in situ were encountered among 454 ectopic gestations at the National Taiwan University Hospital. The cumulative number of Lippes loop users in Taipei City and Taipei County by the end of 1966 was 38,841. The incidence of ectopic gestation has been fairly constant year by year, not being influenced by the rapidly increasing number of IUD users among the population involved.

COMPARISON OF THE VALUE OF 200,000 IU OF TETANUS ANTITOXIN (HORSE) WITH 10,000 IU IN THE TREATMENT OF TETANUS

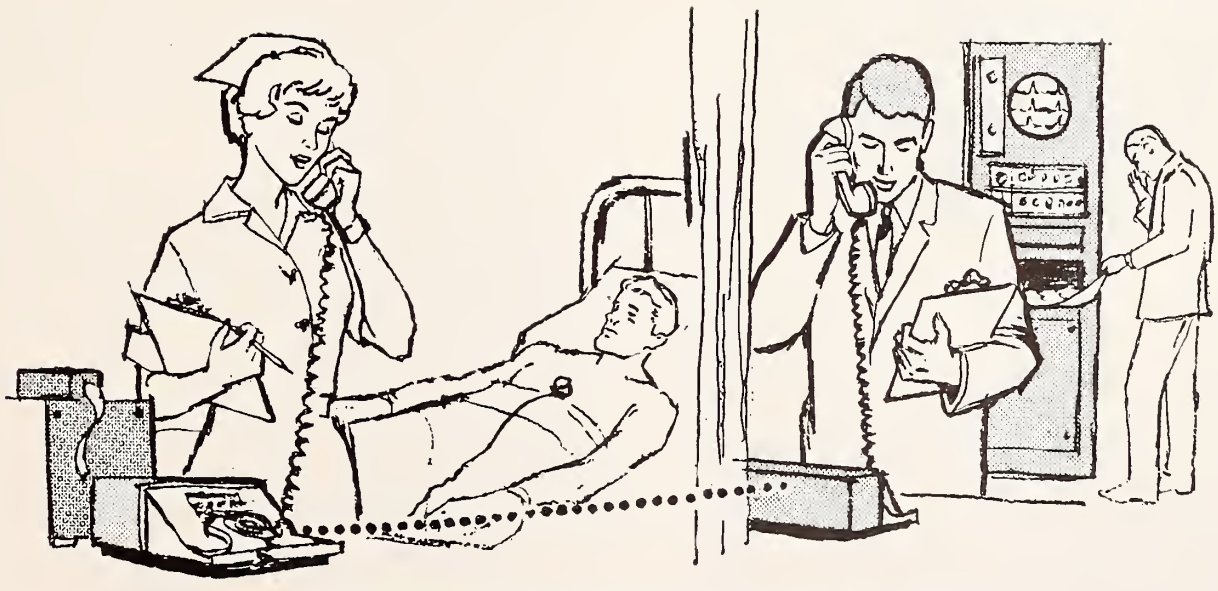
B. J. Vakil et al. (University College Hospital Medical School, London)
Clin. Pharmacol. Ther. 9:465-471, (July-Aug.), 1968.

Equine antitoxin of tetanus was administered to patients and it was concluded that it reduced mortality. It was desirable to discover the minimum effective dose of this expensive and sometimes dangerous treatment. The series comprised doses ranging between 500,000 international units (IU) and 10,000 IU. Antitoxin reduces the mortality in tetanus, and 10,000 IU is an adequate dose.

RADIOACTIVE IODINE IN HYPERTHYROIDISM

H. E. Zellman et al. (H. Matiz, VA Hospital, Buffalo, N.Y.)
Lahey Clin. Found. Bull. 17:137-143, (July-Sept.), 1968.

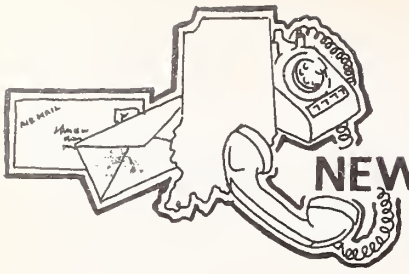
Since 1952 over 700 patients have been treated with iodine 131 at the Lahey Clinic. The results of therapy in 500 of these are reported. Hyperthyroidism was relieved in 470 (94%); 183 had myxedema and 287 were euthyroid without thyroid substance. Thyrotoxicosis persisted and was controlled by antithyroid drugs or iodides in 19. Three required thyroidectomy; eight were not followed up. The chief disadvantage of ^{131}I therapy is an unrelenting increment of myxedema of 3% to 7% per year. ◄



NOW—Practical Centralized Expert Analysis

The Bell System DATA PHONE service concept makes possible transmission of electrocardiograms, electroencephalograms and X-ray data via the regular telephone network. It's fast and economical. Call your Indiana Bell Business Office about it today.

Indiana Bell
Part of the Nationwide Bell System



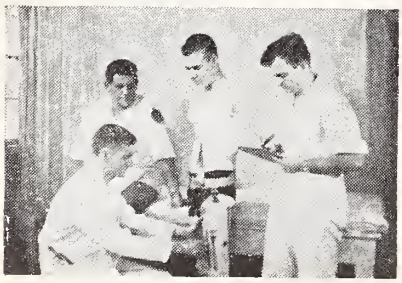
NEWS NOTES

PMA and BLS Studies Show Decline in RX Drug Prices

Two surveys, one sponsored by the Pharmaceutical Manufacturers Association, and the other from the government's Bureau of Labor Statistics, show that prescription drug prices are continuing to decline, while the all-items price index has risen.

According to the PMA study, prepared by Dr. John F. Firestone of the City University of New York, the 1967 manufacturers' drug price level is 85.2 compared to the 1949 base of 100. This index declined from 85.9 in 1966 to 85.2 in 1967. The BLS Wholesale Price Index has fallen 7.2% since 1961, compared to the Firestone Index decrease of 5%. While the BLS Consumer Price Index for all items rose to 120.9 in the first half of 1968 from the 1957-59 base, the Consumer Price Index for prescription drugs dropped to 87.2.

In addition, the average American consumer is spending less of his medical care dollar for prescription drugs. According to Department of Commerce figures, the consumer spent 9.5 cents of each dollar in 1967, as compared to 9.8 cents in 1966, and 11.5 cents ten years ago.



advanced training for HANGER prosthetists

Certified Prosthetists from the various HANGER offices have attended courses on Upper- and Lower-Extremity Prosthetics ensuring that HANGER Clients receive the best Prosthetic Service possible. The courses are approved by the American Board for Certification and given at the U. of California in Los Angeles, Northwestern U., and at New York U., in cooperation with the Committee on Prosthetics Research and Development of the National Academy of Sciences. The use of the Adjustable Leg, the Patellar-Tendon Bearing Below Knee Prosthesis, and the "quadrilateral socket" were features of a series of intensive courses. The curriculum was centered around the Clinical Team (illustrated) usually composed of a physician, a prosthetist and a therapist and concerned with the integrated handling of each amputee case. Thus, doctors, interested in Prosthetics can be assured that HANGER Prosthetists are fully acquainted with the latest prosthetic methods.

Hanger PROSTHESES

1332 N. Illinois St., Indianapolis, Ind. 46202
3108 Burnet Avenue, Cincinnati, Ohio 45229
446 W. Pontiac St., Fort Wayne, Ind. 46807
416 N. Main St., Evansville, Ind. 47711

Dr. Hogle is Speaker

Dr. Frank D. Hogle, North Webster, recently gave a talk on "Present and Future Services of the Four County Mental Health Clinic" at the Community Mental Health Workshop, co-sponsored by the Whitley County Mental Health Association and Zone C (Whitley, Huntington, Kosciusko and Wabash counties) Planning Committee, held at Columbia City.

Dr. Mukhtar is Speaker

Dr. Fuad A. Mukhtar, Lebanon, spoke to the members of the local Kiwanis Club recently on "The Evils of Smoking."

Ohio General Hospital Installs Computerized System for Billing

The Green Cross General Hospital, an osteopathic hospital in Cuyahoga Falls, Ohio is building a 75-bed addition this year and in addition will open an outpatient clinic building and an administrative wing.

What makes it unusual is that the hospital, along with the new additions, is installing a Honeywell Model 120 computer system which will originally handle all inpatient and outpatient accounts. It will also do the payroll for the 700 employees. After this work is running smoothly, the computer will also do statistical and research work.

Dr. Antreasian Elected

Dr. Berj Antreasian, Indianapolis, has been elected president of the Clinical Society of the Indianapolis Diabetes Association. Other new officers include **Drs. R. C. Powell,** first vice-president; **Anthony S. Ridolfo,** second vice-president; **George Klutinoty,** secretary and **M. R. Shafer,** treasurer.

Attends Meeting

Dr. Lester D. Bibler, Indianapolis recently attended a meeting of the Board of Directors of the American Board of Family Practice at Scottsdale, Arizona.

Dr. Smith Assumes Post

Dr. Austin Smith, formerly AMA Editor and more recently president of the Pharmaceutical Manufacturers Association, has been chairman of the board and chief executive officer of Parke-Davis & Company for two years. He will now assume the office of president to replace Harold W. H. Burrows, who retired December 31.

SKF Continues Support Program for College Students' Research Projects

The Smith Kline and French Foundation is continuing an unusual program which is designed to help young people decide on medical careers.

For the seventh summer, the Foundation this year is providing financial assistance which allows 38 college men and women to work for eight to 12 weeks at one of several medical schools. The students are usually assigned to research projects and receive stipends from the SKF Foundation. Thirty-four colleges in Pennsylvania and Ohio contribute the students.

By the end of this summer's program a total of 160 students will have been indoctrinated during the seven years and more than $100,000 will have been expended. More than 85% of the participants in the past have gone into medicine or an allied field.

Dr. Reed Accepts New Position

Dr. Philip B. Reed, Indianapolis, has accepted the position of medical director of the Adult Mental Health Clinics and Emergency Services of Pinellas County, Florida. He will be concerned with clinics in St. Petersburg and Clearwater, and a halfway house, Boley Manor, soon to open in St. Petersburg. Dr. Reed is at present in the private practice of psychiatry and neurology in Indianapolis and is currently vice-president of the American Psychiatric Association. He has been active during his professional career in Indiana in the Indiana Mental Health Association and in psychiatric education. He is chairman of the Grievance Committee of the ISMA and is a trustee of the Levey Memorial Medical Foundation. His new appointment dates from January 1, 1969.

National Fire Protection Association Offers Booklets

The National Fire Protection Association offers a 44-page book "Standard for the Installation of Portable Fire Extinguishers" for $1.00; also a 44-page book "Recommended Good Practice for the Maintenance and use of Portable Fire Extinguishers" for $1.00; and a 196-page book "Standard for the Installation of Sprinkler Systems" for $1.50.

The association has also published a revised manual "Industrial Fire Brigades Training Manual", which is useful in training employees in intramural fire protection.

It covers organizing and training, fire fighting practice with automatic sprinklers, fire causes and hazards, fire extinguishers, use of hoses and fighting various types of fires. It also covers rescue work and care and inspection of plant fire protection equipment.

It is applicable to hospitals and nursing facilities. Price is $5.00. Write to 60 Batterymarch St., Boston 02110 for any of the above publications.

Dr. Roland Elected

Charles G. Roland, M.D., senior editor of *The Journal of the American Medical Association* was selected as president-elect of the American Medical Writers Association at its recent annual meeting in Washington, D.C. Harold Laufman, M.D. and Ph.D., of New York City, will serve as president this year.

Dr. Giffin Named

Dr. Charles S. Giffin, otolaryngologist in Fort Wayne, has been awarded a fellowship in the American Society of Head and Neck Surgery. There are two other members in the state of Indiana: **Dr. Thomas W. Johnson, and Dr. Raleigh Lingeman, both of Indianapolis.**

Dr. Turner Honored

Dr. Anna Goss Turner was the recipient of the 1968 Community Service Award of the city of Madison recently. The occasion was the annual dinner meeting of the Greater Madison Chamber of Commerce. Such awards are not announced previously to the public nor to the recipient and the after-dinner speaker created not only surprise but a tremendous demonstration by all present in appreciation for the many public-spirited services Dr. Turner has rendered the citizens of the community. Dr. Turner has long been known for being long on "do" and short on "talk" and was reported as responding to the occasion by the sincere words—"Thank you."

New Public Affairs Pamphlet Now Available to Physicians

Why does the United States have one of the worst medical care systems in the world? Why will Medicaid solve the problem?

The answers to these two questions are detailed in the latest Public Affairs Pamphlet entitled "Medicaid: the people's health plan." Every physician should have one copy. The price is 25 cents.

Write Public Affairs Pamphlets, 381 Park Ave., South, New York City 10016.

Dr. Davis Heads Medical Program

Dr. Joseph B. Davis, Marion, has been elected chairman of the Regional Advisory Group of the Indiana Regional Medical Program. He succeeds **Dr. George Lukemeyer,** associate dean of the Indiana University School of Medicine. Also elected were **Dr. Joe Black, Seymour,** vice-chairman and **Dr. L. W. Spolyar, Indianapolis,** secretary.

Presents Paper

A new surgical procedure dealing with problems of small bowel obstruction was reported by **Dr. Norman F. Richard, Shelbyville,** at the International College of Surgeons First Western Hemisphere Congress in Honolulu. The title of the paper was "A Non-suture Method of Plication of the Small Bowel."

Continued

Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®: Glyceryl guaiacolate, 50 mg.; Dextromethorphan hydrobromide, 7.5 mg.
A. H. Robins Company, Richmond, Virginia 23220

A·H·ROBINS

Continued

Dr. Marshall Promoted

Dr. Franklin N. Marshall, Indianapolis, has been promoted to assistant department head, Department of Pharmacology, Pitman-Moore Division of Dow Chemical Company. Dr. Marshall is a member of the company's Atherosclerosis and Thrombosis Target Team. He will continue to work on drugs in the heart and circulatory field.

I.U. Presented Film

Roy H. Richardson, vice-president of sales for Barnes-Hind Ophthalmic Products, presented a motion picture training film "Wearing and Care of Your Contact Lenses" to Dr. Charles Shick, director of the contact lens clinic at the Indiana University School of Optometry. The film is designed to assist practitioners in their patient education programs and will be used by the school in the training of optometrists.

Brochure Available Describing Nursing Scholarships and Loans

High school students who have the ability and the ambition to become nurses but need help to go to nursing school will be interested in a brochure describing nursing scholarships, or Nursing Edueational Opportunity Grants, which are available through nursing schools under a recent amendment to the Nurse Training Act.

This illustrated brochure, "Nursing Educational Opportunity Grants—Information for Students," is a publication of the Division of Nursing, Bureau of Health Manpower, an agency of the National Institutes of Health. It explains that scholarship aid of $200 to $800 a school year is available to students of exceptional financial need and also discusses loans for nursing education. This brochure, in addition, helps potential nurses to decide which type of nursing practice to prepare themselves for; cautions them to take the high school courses required for admission to a nursing education program; and offers suggestions and leads for becoming informed about nursing careers and choosing a nursing school.

For complimentary copies of "Nursing Educational Opportunity Grants—Information for Students," contact the Division of Nursing, 800 N. Quincy St., Arlington, Va. 22203.

Dear Doctor, Nurse and Receptionist:

If you will mention our shoe store and our corrective Orthopedic Shoemaking to your patients and friends, we will do our very best to please them and help solve their foot and shoe problems.

Shoe Prescription Service for Man, Woman, Child

Heid's HEALTH SHOE STORE
411 N. ILLINOIS
DRIVE-IN PARKING
INDIANAPOLIS, IND.

AFNB—Midwest Charge
ME5-4247

BETTY MAKSL, (right) Fort Wayne, Ind., accepts the state's third place publications award in the "states with membership over 200" category from Wilda Haines, Canton, Ohio, awards chairman of the American Association of Medical Assistants. Mrs. Maksl, editor of the "Med 'A' Scoop", accepted the award at AAMA's 12th annual convention in Columbus, Ohio.

Dr. Corcoran Elected

Dr. Patrick J. V. Corcoran, Evansville internist and president of the Indiana State Medical Association, has been elected to membership in the Regional Advisory Group of the Indiana Regional Medical Program.

Dr. Griffin is Speaker

Dr. L. W. Griffin, Indianapolis, spoke on "Menmanship" at a recent meeting of the Mid-Indiana Association of Industrial Nurses, Inc. The meeting recognized retiring members of the association.

American Hospital Association Organizes Regional Advisory Boards

The American Hospital Association has organized nine Regional Advisory Boards to improve both the efficiency and effectiveness in the delivery of health services.

Its express purpose is to provide a better mechanism through which the health field may explore its problems more quickly, exchange points of view, communicate decisions and respond to the public needs in matters of health care.

Each of the nine Regional Boards will be composed of the AHA delegates from the regions represented on the board and the executive directors of the state hospital associations in each region.

Indiana is in the region which includes Canada, Illinois, Michigan, Ohio and Wisconsin. Comprehensive health planning, regional medical programs, state mental health and retardation programs will be included in the subjects to be considered originally.

DR. RICHARD E. LINDSETH, (right) assistant professor of orthopedic surgery at the Indiana University School of Medicine, receives a check for $4,500 from Warren Hilleke, treasurer of the Indiana Society for Crippled Children and Adults—the Easter Seal Society. The money is to help subsidize Dr. Lindseth's project in dwarfism, which has two phases. The first is a clinical study of the effects of bracing on the development of dwarf children using the new brace designing and fabrication facility at the medical center. The second is a study of the dwarf child from a biochemical point of view to attempt to find and correct the biochemical abnormality causing dwarfism.

Dr. Hinman Named

Dr. Charles W. Hinman has been named assistant director of Research for the Life Sciences for the Dow Chemical Company. He has been serving as the director of Scientific Relations for Dow's Human Health Business. He will move from Indianapolis to Midland, Michigan.

Physicians Receive Degrees

Dr. Wemple Dodds, Crawfordsville, and Dr. James G. Lorman, Fort Wayne, recently received the fellowship degree of the American College of Radiology. The degree was also awarded to 87 other radiologists for outstanding contributions to medicine.

Indiana Medical Assistant Elected AAMA Vice-President

Mrs. Mildred Crawford, San Antonio, Texas, is the newly elected president of the American Association of Medical Assistants. She was installed at the 12th annual convention in October in Columbus, Ohio.

A certified medical assistant in both the clinical and administrative categories, Mrs. Crawford has been a medical assistant for 35 years. For the past seven years, she has worked for four surgeons in San Antonio — Drs. Albert W. Hartman, William J. Hills, William L. Sammis, and Aureliano A. Urrutia.

Mrs. Marie Young, Indianapolis, was elected vice-president of the association. On the national level, Mrs. Young is completing her third year as trustee and has been a member of the education, nominating and research and development committees. She has served as a delegate from Indiana three times.

A past-president of both her local and state medical assistant associations, Mrs. Young has also been state chairman of the legislative and membership committees.

For the past ten years, Mrs. Young has been secretary and receptionist for Dr. Lowell Thomas. Previously she worked as a secretary to the president of a photoengraving firm.

Mrs. Young is a leader in a women's church group, the president of her local sorority, and has worked with the local high schools on their career day programs.

Dr. Sputh Speaks

Dr. Carl B. Sputh, Indianapolis, presented a scientific paper before the International College of Surgeons' First Western Hemisphere Congress in Honolulu recently. His subject dealt with a series of 132 cases of nasal injury severe enough to require surgical intervention.

Dr. Gelston Promoted

Dr. Robert H. Gelston has been assigned to a newly-created post of manager of Market Planning and Development for Pitman-Moore. Dean Work will have another newly-created post in the same department, that of manager of International Market Development.

Continued

Automobile Leasing

All Types Available

12 Months or Longer

If You Want To

Know The Facts

CONSULT OUR SPECIALISTS

Phone 317-253-4415

Quality Leasing, Inc.

6310 GUILFORD AVE.
INDIANAPOLIS, IND.

Hoosier Physicians Honored For Vietnam Voluntary Service

Dr. Durward G. Hall, Representative in Congress from Missouri, is quoted in *The Congressional Record* as rendering tribute to those physicians who have served on a voluntary basis in Vietnam with the civilian health services of that country.

Dr Hall included in *The Record* the names of 483 American physicians who have served between July 1, 1965 and June 30, 1968. The roster includes sixteen Hoosiers, listed below, with appropriate recognition for two tours of duty in one case and three tours in one other:

Andrew J. Bacevich, Hammond
J. B. Bennett, Warren
George R. Bloom, Elkhart
C. R. Bowers, Anderson[3]
Dale L. Carlberg, Jeffersonville
Harry L. Craig, Huntingburg
Arthur H. Girod, Decatur
John J. Hartman, Angola
Donald J. Kerner, Indianapolis
Kenneth M. Lehman, Topeka
Daniel E. McLaren, Indianapolis
Patricia K. Mosely, Indianapolis (Calif.)[2]
Gilbert H. White, Jr., Hammond

Wins Annual Award

Victor A. Yanchik, who received his doctorate in clinical pharmacy from Purdue University this summer, has been named winner of the fourth annual award given by the Parenteral Drug Association for the best program of research in parenteral medication. The award of $1,000 and a plaque were presented in New York City. Yanchik's research dealt with the absorbing or altering of drugs by rubber stoppers used to seal parenteral solutions.

Dr. Kerrigan Elected

Dr. John F. Kerrigan, Michigan City, has been elected president of the board of directors of the Michigan City United Fund. He will serve for one year.

Dr. Lyon Leads Discussion

Dr. William C. Lyon, Ft. Wayne, recently lead a group discussion on the topic of "Suicide" at a meeting of the Academy of Religion and Mental Health at the Fort Wayne State Hospital and Training Center.

Crittenton Home of Cleveland Offers Services to Unwed Mothers

The Florence Crittenton Home of Cleveland announces that its facilities for the care of pregnant unmarried women are available to residents of states other than Ohio. Under the circumstances, many such patients prefer to seek professional care in a location other than their own home community.

The 47 Florence Crittenton Homes in the United States specialize in high-grade professional care in a residential setting with delivery and other medical services provided in leading medical centers. For further information write Florence Crittenton Home, 8615 Euclid Ave., Cleveland 44106 or telephone (216) 721-2811.

HARDING HOSPITAL

WORTHINGTON, OHIO

A fully accredited private psychiatric hospital situated on 45 acres of beautiful, wooded grounds just ten miles north of the state capitol.

THE HARDING HOSPITAL PROVIDES:

* 125 In-patient beds —
* Day Hospital program —
* Full time attending staff of psychiatrists —
* Professionally trained Adjunctive Therapy staff with programs in occupational, recreational and vocational therapy. (Crafts, Fine Arts, Greenhouse, etc.)
* Qualified staff of psychologists —
* Social Service department —
* Consultation and evaluation for out-patients.

For particulars on rates and terms or on specific patients write or call —

Harding Hospital - Worthington, Ohio
Area Code 614 - 885-5381

George T. Harding, M.D.
Medical Director

Donald L. Hanson
Administrator

Dr. Steen Elected

Dr. Lowell H. Steen, Hammond, internist and ISMA president-elect, has been elected to membership in the Regional Advisory Group of the Indiana Regional Medical Program.

Dr. Bowen Speaker

Dr. Otis E. Bowen, Bremen, was recently guest speaker for the Business and Professional Women's Club in Marion.

Eli Lilly & Company Will Redesign All Pharmaceutical Labels

Eli Lilly is redesigning most of their pharmaceutical labels to feature greater clarity and legibility. The well known red "Lilly" will appear at the top of the new label to emphasize the fact that the identify of the maker is an important factor in choosing quality. Approximately 4,000 labels will be revised, a process which will require over a year.

Dr. Clark Honored

The Hearing and Speech Center of St. Joseph County presented its Award of Merit to **Dr. William H. Clark, South Bend** ear, nose and throat specialist at a recent meeting. He was selected because of his years of service to the hearing and speech handicapped of St. Joseph County.

Dr. Mullican is Speaker

Dr. William S. Mullican, Evansville, spoke at a kick-off dinner of the Dubois County Heart Fund drive recently at the K. of C. Home in Jasper.

Dr. Shumacker Honored

Dr. Harris B. Shumacker, retiring chairman of the department of surgery at the I.U. School of Medicine, is the 1968 recipient of the Roswell Park medal of the Buffalo (N.Y.) Surgical Society. The award is presented annually to an outstanding surgeon.

Dr. Geckler Appointed

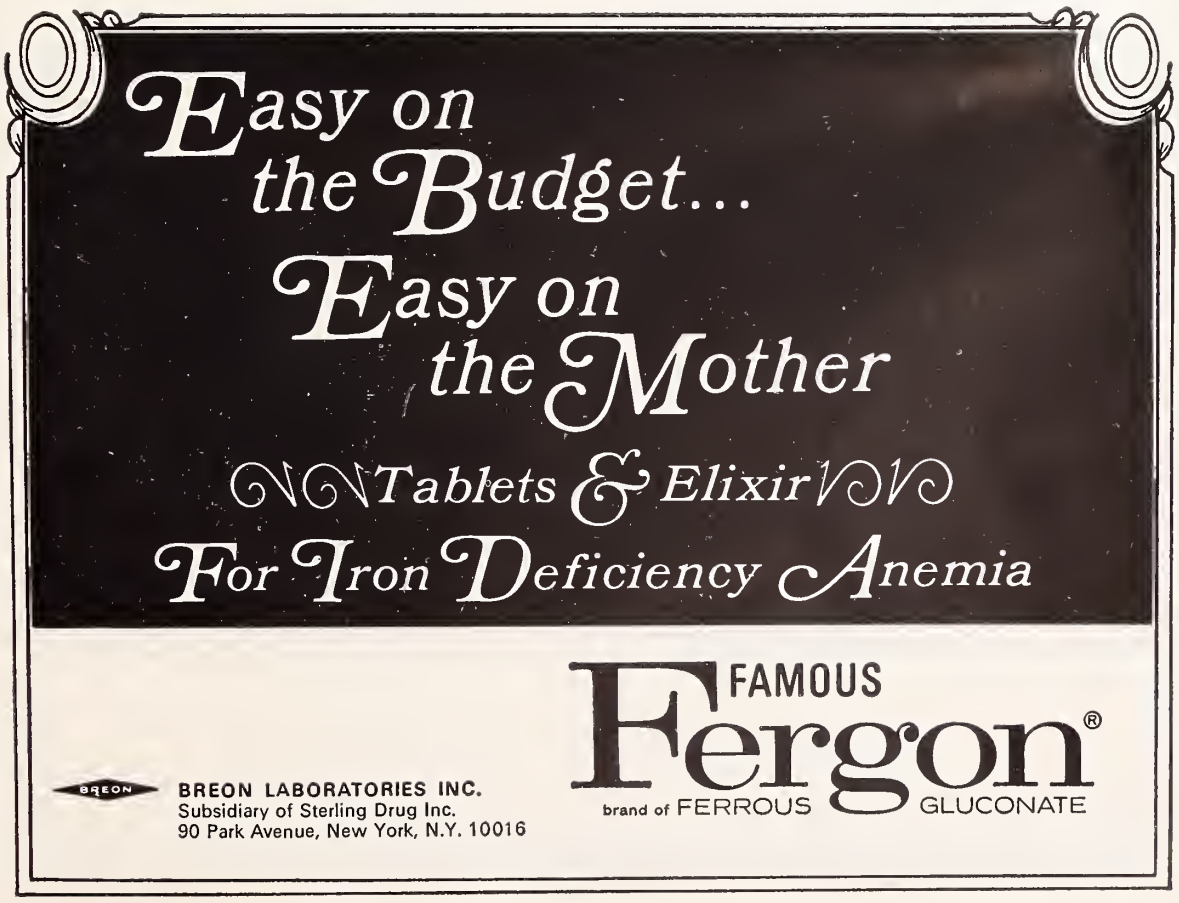
Dr. Charles E. Geckler, Muncie, has been added to the medical staff to practice anatomic pathology at the Blackford County Hospital.

Doctors Named to Academy

Dr. Hansel O. Foley, South Bend; Dr. Douglas A. Bailey, Marion; Dr. Harry T. Stout, Frankfort; Dr. Charles O. Weddle, Lebanon; Dr. John Van Wienen, Martinsville; Dr. Clarence W. Worth, Milroy; Dr. Ted C. Kirby, Greenfield; Dr. Philip E. Yunker, Howe; Dr. Leslie E. Bombar, Munster; Dr. Perry F. Seal, Brookville; Dr. B. D. Wagoner, Union City; Dr. Wilbur P. Beeson, Greenfield; Dr. Donald C. Miller, Cedar Lake; Dr. Irving Cohen, Plainfield; Dr. Fred M. Blix, Ladoga and Dr. Richard R. Eggers, Crawfordsville, have been elected to active membership in the American Academy of General Practice.

Dr. Brooks Guest Speaker

Dr. Edwin A. Brooks, Evansville anesthesiologist, recently delivered the sermon at the Seventh-Day Adventist church. He spoke on "Death, Burial and Resurrection of Jesus." ◄



From *The Journal* 50 Years Ago

The high, narrow palate, harelip, scaphoid scapulae, short arms, hypoplastic teeth, etc., are looked on as evidences of hereditary syphilis. We should suspect the possibility of hereditary syphilis in individuals whose chief characteristic is a general inferiority.

There is no tissue in the human body that is exempt from the ravages of syphilis. The eye, with all of its complexity and delicacy of mechanism, is very frequently the seat of inflammatory and degenerative changes directly due to the syphilitic infection, either hereditary or acquired.

Many years ago I was accused of being ultraradical in my views when I stated that I believed that fully 50 to 60 percent of all eye affections were due to syphilis, and my confreres have thought my judgment rather biased when I stated that in the majority of instances, if a physician knew of no other treatment to prescribe, he would make no mistake in giving antisyphilitic remedies. As a matter of fact I was taught to recognize certain lesions as being probably syphilitic, whether generally recognized as such or not, and the therapeutic tests have generally proven the correctness of the conclusion. With increasing years and experience I have grown more settled in my conviction as to the pathognomonic character of certain eye lesions, and with our present-day perfected methods of diagnosis, the opinions of earlier days have been substantiated . . . . Albert E. Bulson, Jr., M.D., Fort Wayne, "Syphilis as it Pertains to the Eye," *JISMA*, December, 1918.

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

INDIANAPOLIS OFFICE:

Kenneth W. Moeller and Philip P. Capasso, Representatives

665 East 61st Street Telephone: 317-255-6525

Mailing Address: P.O. Box 20132, Indianapolis 46220

In peptic ulcer: the antacid puzzle

solved by Mylanta®

aluminum and magnesium hydroxides *plus* simethicone

"will it ease the pain?"

Mylanta helps relieve ulcer pain with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

will it help "my gassy stomach"?

Mylanta *also* contains simethicone: for concomitant relief of G.I. gas distress.

"will this one taste O. K.?"

The *prolonged* acceptance of Mylanta was recently confirmed in 87.5% of 104 patients—after a total of 20,459 documented days of therapy.* *Danhof, I. E.: Report on file.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. *Dosage:* One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

Stuart Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

No two women are quite alike...

and no other oral contraceptive is quite like Ovulen-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

The progestin is distinctive, and for some women this may mean a different clinical response. The Compack® tablet dispenser is distinctive; its functional simplicity makes it virtually patient-proof. The acceptance of Ovulen-21 is distinctive... together with Ovulen®, it is more often prescribed than any other individual contraceptive product currently available.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

SEARLE Where "The Pill" Began
G. D. SEARLE & CO., P. O. Box 5110, Chicago, Illinois 60680

If you think the pink pill for U.R.I. symptoms is built for speed and endurance you're on the right track.

Here is a tablet that begins to relieve symptoms of upper respiratory infection quickly—a tablet that works for hours to make it easy for your patient to enjoy continuous relief.
Novahistine Singlet combines effective dosage of an antipyretic-analgesic with a vasoconstrictor-antihistamine formulation to relieve not only the congestion, but also the fever and the aches and pains that almost always accompany upper respiratory infections.

A total daily dosage of 3 or 4 tablets will normally provide the continuous relief your patient expects. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, Indiana.

Novahistine®
Singlet decongestant-analgesic

(Each tablet contains: phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; acetaminophen, 500 mg.)

DOW

Deaths

Horace M. Banks, M.D.

Dr. Horace M. Banks, 78, retired Methodist Hospital pathologist, died Sept. 10 in an Indianapolis nursing home.

Graduated from Johns Hopkins University in 1917, Dr. Banks was director of clinical laboratories at Methodist Hospital from 1927 to 1957 and served as research pathologist until his retirement in 1960. He served in the U.S. Army during both world wars.

From 1941 to 1943 and from 1946 to 1956, Dr. Banks was a deputy coroner of Marion County. For seven years he was consultant in pathology at the former City Hospital and four years for Veterans Hospital, on Cold Springs Road. He was a Senior Member of ISMA, a member of the 50-Year Club and the Marion County Medical Society.

John W. A. Emhardt, M.D.

Dr. John W. A. Emhardt, an Indianapolis physician and surgeon 57 years, died Oct. 28 in Methodist Hospital. He was 79.

Dr. Emhardt received his medical degree from the I.U. School of Medicine in 1911 and a master of science in surgery degree from the University of Pennsylvania in 1929. He also studied surgery for one and one-half years at the University of Vienna.

In 1940, he built the Emhardt Memorial Hospital at Indianapolis and was its director 10 years before turning it over to the Suemma Coleman Home. He also had been an instructor in surgery at the I.U. Medical School and was on the active staff of Methodist Hospital, the consulting staff of General Hospital and the courtesy staff of St. Vincent's Hospital. He was a Senior Member of ISMA, a member of the 50-Year Club and the Marion County Medical Society.

Carl M. Hostetler, M.D.

Dr. Carl M. Hostetler, practicing physician in Goshen for 24 years before joining the staff at the University of Wisconsin last year, died Oct. 2 at Elkhart at the age of 57.

Dr. Hostetler was clinical instructor of medicine at the university's student health center at Madison, Wis. Graduated from Western Reserve University's School of Medicine in 1941, Dr. Hostetler practiced in Goshen from 1943 to September, 1967. He was a member of the Elkhart County Medical Society.

James J. Kistler, M.D.

Dr. James J. Kistler, 63-year-old LaPorte general practitioner, died Sept. 23. He had practiced in LaPorte since 1932.

Dr. Kistler, who was graduated from the I.U. School of Medicine in 1930, went to LaPorte in 1932 and practiced there until 1942, when he became a surgeon in the U.S. Army. After his Army service, he resumed his practice at LaPorte. He was a member of the LaPorte County Medical Society.

Charles J. McIntyre, M.D.

Dr. Charles J. McIntyre, retired Indianapolis tuberculosis specialist, died Sept. 23 at the Zionsville Nursing Home. He was 90 years old.

Dr. McIntyre, who conducted chest clinics throughout the state for many years, was graduated from the I.U. School of Medicine in 1906. A resident of Indianapolis 58 years, he taught at the I.U. Medical School from 1925 to 1950. He retired from practice in 1958.

Dr. McIntyre served as an Army surgeon during World War II and for more than 25 years headed the Tuberculosis Clinic at Marion County General Hospital. He had served as president and treasurer of both the state and Marion County Tuberculosis Associations. Dr. McIntyre was a Senior Member, a member of the ISMA 50-Year Club and the Marion County Medical Society.

Richard F. Richie, M.D.

Dr. Richard F. Richie, retired head psychiatrist at Beatty Memorial Hospital, Westville, died the latter part of September in Laguna Hills, Calif.

A former member of the LaPorte County Medical Society, Dr. Richie had moved to the west last November, after being associated with Beatty for five years.

Walter E. Stewart, M.D.

Dr. Walter E. Stewart, 82-year-old Terre Haute ophthalmologist and otolaryngologist, died Sept. 10 at Union Hospital there.

Dr. Stewart, who practiced his specialty in Terre Haute for 40 years, retired in 1958. He was graduated from the University of Oklahoma School of Medicine in 1912. He was a Senior Member of ISMA, a member of the 50-Year Club and a former member of the Vigo County Medical Society. ◄

Season's Greetings

CENTRAL BRACE & LIMB CO., Inc.

1901 N. Capitol Ave.
Indianapolis, Ind. 46202
925-4296

406 S. BERKLEY RD.
Kokomo, Ind. 46901
457-4868

Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION ANNUAL CONVENTION
Date July 13-17, 1969
Place New York, N. Y.

NORTHERN INDIANA PSYCHIATRIC SOCIETY
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville

INDIANA PSYCHIATRIC SOCIETY
Date Second Wednesday of the month October through May, excluding December
Place The Athenaeum, Indianapolis

AMERICAN COLLEGE OF SURGEONS INDIANA CHAPTER
Date April 17-19, 1969
Place Purdue University, West Lafayette

INDIANA ACADEMY OF GENERAL PRACTICE
Date April 15-17, 1969
Place Evansville

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY
Date April 30-May 1, 1969
Place Imperial House, Columbus

INDIANA CHAPTER OF AMERICAN ACADEMY OF PEDIATRICS
Date May 14-15, 1969
Place Stouffer Inn, Indianapolis

INDIANA DENTAL ASSOCIATION
Date May 10-14, 1969
Place Murat Temple and Essex House Motel, Indianapolis

INDIANA PUBLIC HEALTH ASSOCIATION, INC.
Date April 22-24, 1969
Place Stouffer Inn, Indianapolis

INDIANA STATE MEDICAL ASSOCIATION CONVENTION
Date October 13-16, 1969
Place Indianapolis

INDIANA ROENTGEN SOCIETY
Date May 4, 1969
Place Holiday Inn, Indianapolis

INDIANA SOCIETY OF ANESTHESIOLOGISTS
Date May 24, 1969
Place Marott Hotel, Indianapolis

INDIANA STATE LICENSED PRACTICAL NURSES' ASSOCIATION, INC.
Date May 5-9, 1969
Place Robert Lee Motel, New Albany

INDIANA STATE NURSES ASSOCIATION
Date October 16-18, 1969
Place Civic Auditorium, Evansville

County, District News

Bartholomew-Brown

"Paleontology: A Fossil Record of Man's Evolution" was the topic of Hugh Rose, vice president in charge of marketing, Cummins Engineering Company, when he spoke at the Oct. 9 meeting of the Bartholomew-Brown County Medical Society. Approximately 30 members attended.

Cass

Dr. G. O. Larson, LaPorte, spoke on the various aspects and activities of the ISMA at the Oct. 2 meeting of the Cass County Medical Society. Field Secretary Howard Grindstaff also attended the meeting, to urge attendance at the convention and review resolutions.

Dearborn-Ohio

William Weber, of the Toastmaster's Club, spoke to both the auxiliary and members of the Dearborn-Ohio County Medical Society at its Oct. 3 meeting.

Elkhart

"Future Plans of Medical Education" was the subject chosen by Dr. George T. Lukemeyer, Indianapolis, when he spoke at the Oct. 3 meeting of the Elkhart County Medical Society.

Huntington

The Huntington County Medical Society met Oct. 8 to hear Dr. Henry Black, of Eli Lilly & Co., head a symposium on antibiotics.

Knox

Officers of the Knox County Medical Society for 1968-69 will be: Drs. Charles R. Miller, president; Thomas L. Barrett, president-elect; Daniel J. Combs, secretary and Malcolm S. Floyd, treasurer. All of the new officers are from Vincennes.

Marshall

Dr. James Hampton, Argos, is the 1968-69 president of the Marshall County Medical Society. Other officers include: Drs. James Coursey, Argos, vice president and Harry Stoller, Plymouth, secretary-treasurer.

Vanderburgh

"To Keough or Not to Keough" was the main topic of discussion at the Oct. 8 meeting of the Vanderburgh County Medical Society. Speakers included A. M. Picucci and N. Eugene Kelley of George S. Olive & Co., certified public accountants.

Wayne-Union

Dr. Charles S. Petty, pathologist at Marion County General Hospital, spoke on "Poisons" at the Oct. 29 meeting of the Wayne-Union County Medical Society. Dr. Petty covered common and uncommon agents producing severe toxic effects in humans, with emphasis on the recent increase in narcotic drug toxicity. ◄

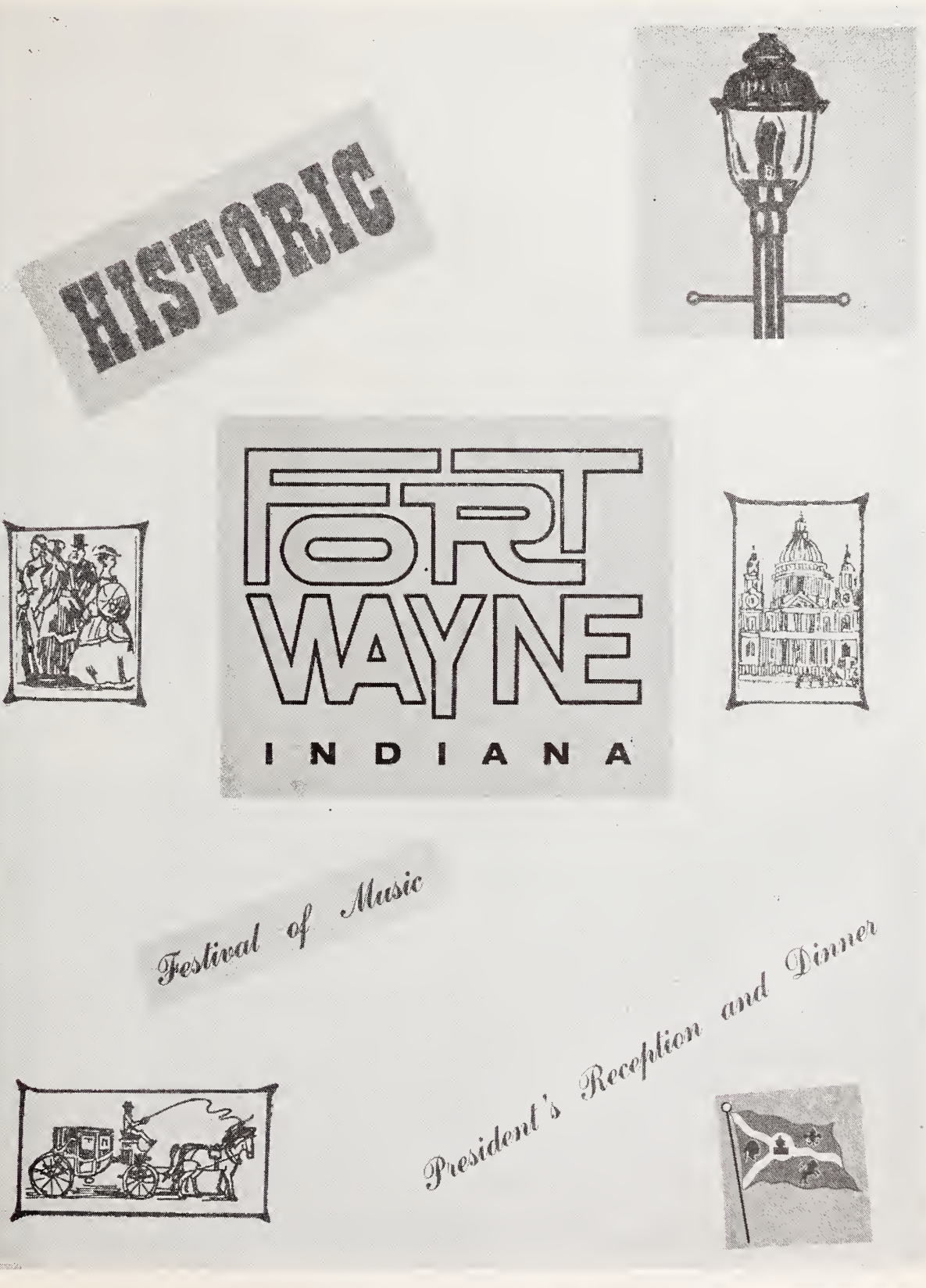
New Booklet on "Alcoholism"

Intensive study by the American Medical Association's Committee on Alcoholism and Drug Dependence of the Council on Mental Health has resulted in the publication of "The Illness Called Alcoholism."

This 16-page brochure, developed for the benefit of the laity, defines alcoholism and delves into its causes, effects, identification and treatability. It stresses that alcoholics *can* be treated successfully and that they are not to be considered "hopeless cases."

What role can a responsible citizen play in the alleviation of this problem of mounting concern? Though not an easy task, one method suggested is to persuade a suspected alcoholic to see his physician. Attempts to conceal drinking and refusal by an individual to admit that he drinks excessively are just two of the numerous symptoms listed to aid in the detection of possible alcoholism.

A complimentary review copy of this new pamphlet, which may be requested by the code number OP-192, is available from the AMA Department of Health Education, 535 North Dearborn Street, Chicago, Illinois 60610. Quantity prices are as follows: 1-49 copies, 20¢ each; 50-99, 18¢ each; 100-499, 16¢ each; 500-999, 14¢ each; 1,000 or more, 12¢ each.



1968 - The Convention Story

THE COUNCIL met for breakfast Tuesday morning to labor over business matters.

REGISTRATION officially signals the beginning of any convention.

THE ANNUAL GOLF TOURNAMENT was held at the Pine Valley Country Club in Fort Wayne this year. Drs. Joseph F. Milan, Brad J. Bomba and William F. Howard watch Dr. George C. Poolitsan get out of a sand trap. All of the physicians are from Bloomington.

PHYSICIANS jam the aisles in the technical exhibitors section.

DR. J. B. BENNETT, of Warren, was presented an AMA Certificate of Humanitarian Service at the first meeting of the House. The certificate honored his volunteer service caring for the civilian population in Vietnamese hospitals.

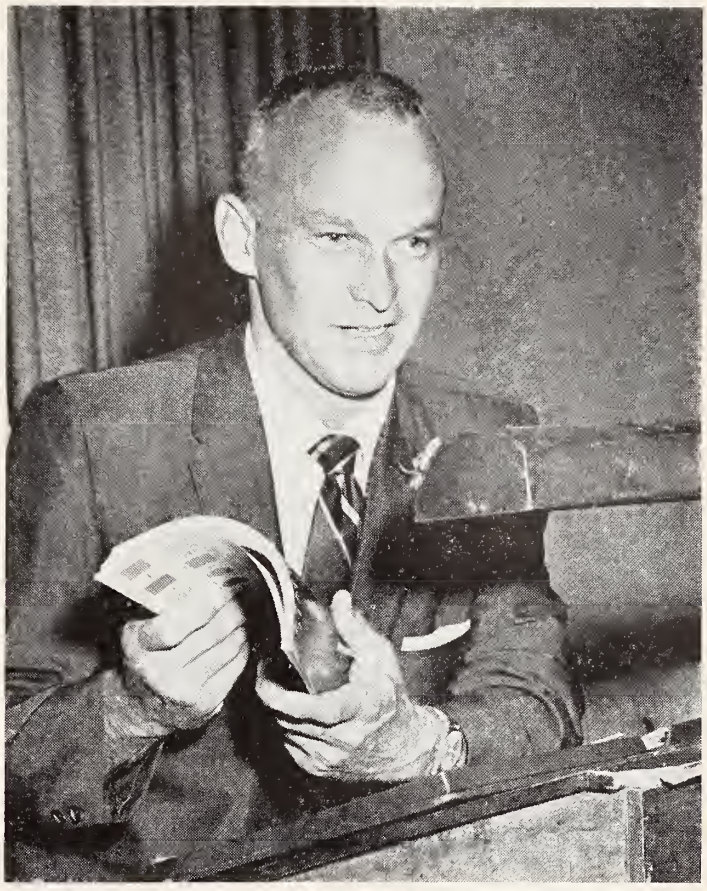
THE HOUSE OF DELEGATES met Tuesday afternoon in the auditorium of the Chamber of Commerce.

THE TWELFTH DISTRICT Medical Society gave a special reception and dinner for ISMA delegates Tuesday night in the Shrine Club.

REFERENCE COMMITTEE NO. 2 met Tuesday evening to deal with a multitude of resolutions.

CLOSED CIRCUIT TV, direct from the I.U. Medical Center in Indianapolis, drew large crowds on Wednesday morning.

THE FIRST Orientation Meeting for New Members was held this year in the Candidates Room at the Scottish Rite. Dr. P. J. V. Corcoran is shown addressing the new members.



SECTION MEETINGS filled the calendar on Wednesday morning. Dr. Jack Schreiber, Canfield, Ohio, spoke before the Section on General Practice.

JOURNAL POLICY PLANNERS: The Editorial Board.

THE PAST PRESIDENTS OF ISMA met for luncheon on Wednesday in the Chamber of Commerce Building.

THE FLYING PHYSICIANS ASSOCIATION also met on Wednesday.

DR. WEI-PING LOH, of Gary, is shown with his scientific exhibit entitled "Hemoglobin S." Dr. Loh won first place in the scientific exhibits and also the Aesculapian Award.

THE FIRST GENERAL MEETING featured a symposium on "Surgical Aspects of Trauma."

DR. LEONARD L. NESBIT, Anderson, tries out a neck brace at the DePuy Manufacturing Company booth in the technical exhibits.

DR. FRANK B. RAMSEY and Dr. Charles P. Schneider, co-chairman of the Art and Hobby Show, discuss one of the exhibits entered this year. This exhibit, entered by Dr. Russell J. Morrical, Logansport, featured all types of dolls, toys, ships and animals made out of hospital disposables.

RECEPTION for members of the Fifty-Year Club was held prior to the President's Reception and Dinner Wednesday night at Cutter's Chalet. Attending were Drs. E. S. Jones, Hammond; H. M. English, Gary; Don F. Cameron, Angola; H. C. Parker, Hobart; Herman Baker, Evansville and Ernest A. Hershey, Churubusco.

THE PRESIDENT'S RECEPTION started off the proceedings for the President's Dinner.

THE HEAD TABLE at the President's Dinner.

SENATOR GEORGE MURPHY was the principal speaker at the dinner.

DR. J. O. RITCHEY, Indianapolis, gave the response for the Fifty-Year Club.

OVERALL picture of the crowd which attended the President's Dinner at Cutter's Chalet in Fort Wayne.

DR. WEI-PING LOH, Gary, won first place in the scientific awards and also the Aesculapian award for his exhibit on "Hemoglobin S."

DR. J. WILLIAM WRIGHT was awarded the second place award for his scientific exhibit.

THIRD PLACE AWARD in the scientific exhibits went to Dr. E. T. Edwards, former Indiana physician.

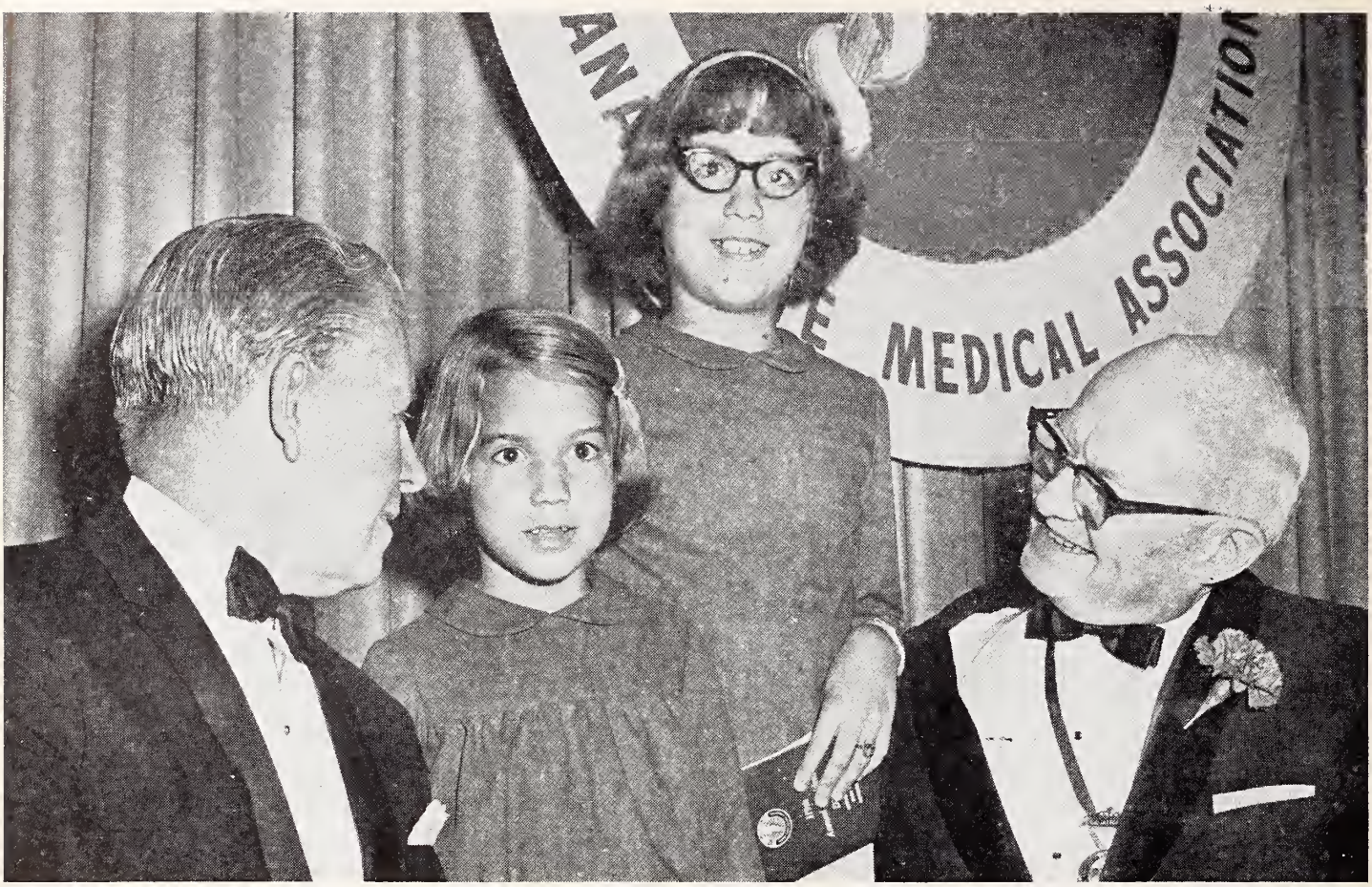
THE PHYSICIAN OF THE YEAR AWARD, presented by the Mental Health Association in Indiana, went to Dr. William G. Bannon, Terre Haute.

FRED N. SIEVERS, Evansville Press reporter, won a public relations award for his five-part series on Medicare.

RADIO STATION WOWO, Fort Wayne, was winner of a public relations award for a series on a syphilis epidemic. The series urged early check-ups for venereal disease.

JAMES A. WAGGENER, executive secretary of ISMA, was made an Honorary Member of the association and presented his plaque at the dinner.

DR. PATRICK J. V. CORCORAN presents the president's plaque to Dr. G. O. Larson, retiring president.



CINDY AND JULIE BARKER, Dr. Larson's granddaughters, went up to the speaker's table to ask Senator Murphy for his autograph after the dinner.

THE GENERAL MEETING on Socio-Economic matters was held Thursday morning in the Theatre of the Scottish Rite.

THE WOMAN'S AUXILIARY went on a special bus tour of historic sites in Fort Wayne.

LUNCHEON for the Women Physicians of Indiana was held at the Fort Wayne Country Club.

THE LAST GENERAL MEETING of the convention was held Thursday afternoon and featured a discussion on the "Diagnosis and Treatment of Coronary Diseases."

JOHN TWYMAN, Executive Director of the Lake County Medical Society, and Mrs. Alvin J. Haley, Fort Wayne, "talk with" part of the entertainment at the Music Festival held Thursday night at The Lantern.

DR. AND MRS. MAURICE GLOCK dance to the music of the combo at the Music Festival. Dr. Glock was local convention arrangements chairman.

THE CONCORDIA SINGERS delighted the audience at the Music Festival.

THE HOUSE OF DELEGATES met for its final session on Friday morning.

DR. G. O. LARSON places the presidential medallion around the neck of Dr. Patrick J. V. Corcoran.

THE NEW OFFICERS of the association are shown being sworn into office.

DR. CORCORAN congratulates Dr. Lowell H. Steen on his election to the post of president-elect.

1910 Physician's Office Highlight of Fort Wayne

JACKIE STAHL
Assistant Editor, The Journal

DRS. RICHARD C. DATZMAN AND ALVIN J. HALEY look at a stereopticon which was donated along with other medical instruments.

TALK about "medical miracles!"

The rudimentary tools with which the 1910 physician had to work makes one wonder how any patients survived the treatment, let alone the disease.

Approximately one year ago, the offices of the Fort Wayne (Allen County) Medical Society became a collection depot for antique instruments, books and other donations from retiring physicians in the area. In collaboration with the Allen County-Fort Wayne Historical Society, it was decided to recreate a physicians's office from the 1900's on the third floor of the Historical Museum.

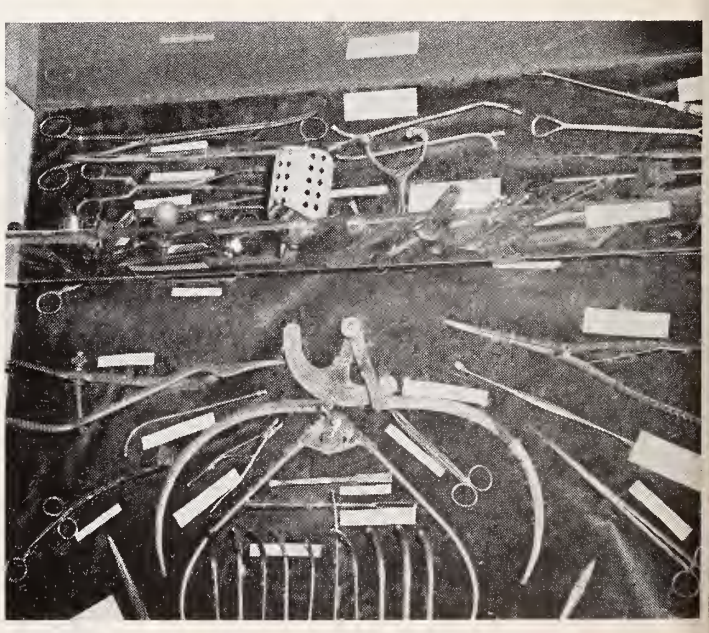
The committees from the two organizations spent months sorting and identifying the medical artifacts, deciding what to put into the exhibit and what to discard as from another era.

What they finally came up with is certainly a tribute to the fortitude, ingenuity and determination of the old-time physician. Besides worrying with diphtheria, smallpox, pellegra and rabies, the doctor mixed his own mendicaments, operated in his office and then packed his saddlebags and got on his horse to make house calls.

The exhibit depicts a physician operating in his office, performing a tonsillectomy on a small boy. Equipped with a can of ether, the doctor has a cone pressed over the boy's nose, administering the anesthetic. Blood-stained rags are very much in evidence in the wastebasket.

A wood-burning stove, gas light, rolltop desk, mortar and pestle and

THE EXHIBIT depicts a physician of the 1900's operating in his office.



PART of the collection of medical artifacts which compose the exhibit.

an authentic diploma are parts of the exhibit. Even the wallpaper is a replica of the type used in the 1900's. Bound volumes of *The Journal of the American Medical Association* are included in the office, as well as jars and bottles full of herbs and nostrums, reminiscent of the day when physicians had their own apothecaries.

Display cases of old and unusual instruments invite hours of browsing. Included are a primitive microscope, a blood count apparatus, saddle bags, an electric shocker, a person-to-person transfusion set and long-hand notes made by a medical student in 1892. There are also liquor prescription blanks used during Prohibition and a polyp snare made by some ingenious physician from a bicycle spoke.

One especially interesting part of the exhibit is an actual hospital record of 1916 from the Lutheran Hospital. The patient, suffering from "rose spots on the abdomen" or typhoid fever, was given a diet of "milk toast, peach juice, oatmeal, orange juice, broth, crackers and custard." The treatment evidently worked as the temperature chart goes down on each succeeding day.

The exhibit, which was officially dedicated September 25, will continue to grow, according to Dave Drury, curator of the museum. "Things are still coming in," he said, "and we plan to expand the exhibit to include a lot of them."

Another unusual donation, not yet included in the display, is a stereopticon, complete with pictures of various dermatitides of the 1900's. One patient has on suspenders and several of the others have ruffled lace collars and cuffs. Dr. Richard C. Datzman, chairman of the committees from the Fort Wayne Medical Society and the Historical Society, said that he hopes that the stereopticon will become part of the exhibit when it is expanded so that children will be able to use it. ◄

DR. DATZMAN sits at the rolltop desk which is a part of the display.

OVERALL view of the physician's office.

Convention Election Results:

Dr. Lowell H. Steen is Named President-Elect

Dr. Lowell H. Steen, Hammond physician, was elected president-elect of the Indiana State Medical Association at the closing session of the House of Delegates in October.

Dr. Steen, a specialist in internal medicine, is in private practice at the Whiting Clinic in Hammond. A 1948 graduate of the Indiana University School of Medicine, Dr. Steen is on the active staff of St. Catherine's Hospital in East Chicago where he served as chief of its medical service from 1962-64.

A member of the Lake County Medical Society, Dr. Steen has served as chairman of the association's Board of Trustees and as a member of that body for six years. In addition to membership in many professional medical organizations, he is a member of the American Society of Internal Medicine, a former president of the Indiana Society of Internal Medicine and a Fellow of the American College of Physicians.

His military service included duty as a surgeon with the 25th Division Artillery from 1949-50 and chief of medical service with the U.S. Army hospital in Salzburg, Austria, from 1955-56.

Also taking office during the convention were Drs. Lester H. Hoyt, Indianapolis, re-elected treasurer; M. O. Scamahorn, Pittsboro, re-elected assistant treasurer and Donald R. Taylor, Muncie, elected chairman of the Board of Trustees. Dr. Ralph V. Everly, Indianapolis, was re-elected chairman of the Executive Committee and Dr. Burton E. Kintner, Elkhart, was re-elected to the Executive Committee.

Dr. Don E. Wood, Indianapolis, was elected as delegate to the American Medical Association for a two-year term beginning December 31, 1968 and Drs. James A. Harshman, Kokomo and Eugene S. Rifner, Van Buren, were named alternates. Other delegates who will represent ISMA and whose terms expire in December, 1970, are: Drs. Eugene F. Senseny, Fort Wayne and Frank H. Green, Rushville. Dr. Kenneth O. Neumann, Lafayette, was re-elected alternate.

Taking over their official duties as new trustees for their districts at the convention were Drs. James H. Gosman, Indianapolis, Seventh District and Vincent J. Santare, Munster, Tenth District. Re-elected to new three-year terms as trustees were: Drs. Gilbert M. Wilhelmus, Evansville, First District; Robert M. Reid, Columbus, Fourth District and Otis R. Bowen, Bremen, Thirteenth District.

Dr. Lindley Wagner, Lafayette, was elected alternate trustee from the Ninth District and Dr. Charles T. Disney, Gary, was elected to fill the unexpired term of Dr. Herman Wing, Gary, Tenth District. Re-elected alternate trustees were: Drs. Betty Dukes, Dugger, Second District; Elmer L. Wallace, New Albany, Third District; James A. Harshman, Kokomo, Eleventh District and Frederic L. Schoen, Fort Wayne, Twelfth District.

Results of the various section elections are as follows:

Section on Surgery: Chairman—Henry Larzelere, Marion; Vice-chairman—Austin Gardner, Indianapolis; Secretary—Robert Rang, Washington.

Section on Internal Medicine: Chairman—Louis Sandock, South Bend; Vice-chairman—Evart M. Beck, Indianapolis; Secretary—Robert L. Rudesill, Indianapolis.

Section on Ophthalmology and Otolaryngology: Chairman—David E. Brown, Indianapolis; Vice-chairman—Kenneth F. Isenogle, Fort Wayne; Secretary—George A. Clark, Indianapolis.

Section on Anesthesiology: Chairman—Robert W. Vermilya, Lafayette; Vice-chairman—William M. Sholty, Lafayette; Secretary—Adolph P. Walker, East Chicago.

Section on General Practice: Chairman—Robert W. Mouser, Indianapolis; Vice-chairman—Richard Juergens, Fort Wayne; Secretary—Robert Acher, Greensburg.

Section on Obstetrics and Gynecology: Chairman—Tom W. Wachob, Jr., Kokomo; Vice-chairman—Charles R. Echt, Indianapolis; Secretary—Barton T. Smith, Marion.

Section on Public Health and Preventive Medicine: Chairman—Bertram F. Duckwall, Terre Haute; Secretary—Louis E. How, South Bend.

Section on Radiology: Chairman—John A. Robb, Indianapolis; Vice-chairman—Robert E. Beck, Evansville; Secretary—Dale B. Parshall, Elkhart.

Section on Nervous and Mental Diseases: Chairman—Robert O. Bill, Indianapolis; Vice-chairman—Richard L. Shriner, South Bend; Secretary—Wesley A. Kissel, Indianapolis.

Section on Pathology and Forensic Medicine: Chairman—Robert J. Frost, Michigan City; Secretary—Robert L. Costin, Indianapolis.

Section on Pediatrics: Chairman—Roland E. Miller, Lafayette; Vice-chairman—Gustaf W. Erickson, South Bend; Secretary—Morris Green, Indianapolis.

Section on Directors of Medical Education: Chairman—Donald T. Olson, South Bend; Vice-chairman and Secretary—Franklin A. Bryan, Fort Wayne. ◄

THE WINNERS—119th Annual Convention Fort Wayne, Oct. 15-18, 1968

MEN'S ART AND HOBBY SHOW

Oil Painting:
First: T. T. Suzuki, M.D., Covington
Second: Charles P. Schneider, M.D., Evansville
Third: Dr. Suzuki, Covington

Honorable Mention:
Dr. Suzuki, Covington
Dr. Schneider, Evansville
Dr. Ray H. Burnikel, M.D., Evansville

Watercolor Painting:
First: W. L. Harlan, M.D., Evansville
Second: Lester Borough, M.D., South Bend
Third: Dr. Harlan, Evansville

Photograph—Black and White:
First: Robert Green, M.D., Fort Wayne
Second: Dr. Green, Fort Wayne
Third: Dr. Green, Fort Wayne

Honorable Mention:
Walter A. Dycus, M.D., Evansville

Photograph—Color:
First: Robert Green, M.D., Fort Wayne
Second: Dr. Green, Fort Wayne
Third: Walter A. Dycus, M.D., Evansville

Honorable Mention:
Truman Caylor, M.D., Bluffton
Malcolm Scamahorn, M.D., Pittsboro

Crafts:
First: William D. Ritchie, M.D., Evansville
Second: Dr. Ritchie, Evansville
Third: Dr. Ritchie, Evansville

Honorable Mention:
William D. Ritchie, M.D., Evansville

Special Exhibit:
First: Herman G. Haffner, M.D., Fort Wayne

Hobbies and Collections:
First: Russell J. Morrical, M.D., Logansport

Handicraft:
First: Malcolm M. Scamahorn, M.D., Pittsboro

WOMAN'S AUXILIARY ART AND HOBBY SHOW

Oil Painting:
First: Mrs. Kitty Wolf, LaPorte
Second: Mrs. Wolf, LaPorte
Third: Mrs. Wolf, LaPorte

Honorable Mention:
Mrs. J. C. Richter, LaPorte
Mrs. Kitty Wolf, LaPorte

Craft:
First: Mrs. Ray H. Burnikel, Evansville
Second: Mrs. C. C. Young, Jr., Evansville
Third: Mrs. Burnikel, Evansville

Handicraft:
First: Mrs. W. D. Ritchie, Evansville
Second: Mrs. Ritchie, Evansville
Third: Mrs. Martha Heinrich, Evansville

Sculpture:
Mrs. Kitty Wolf, LaPorte

SCIENTIFIC EXHIBIT AWARD WINNERS

Award No. 1—Wei-Ping Loh, M.D., Gary Methodist Hospital, Gary—HEMOGLOBIN S.

(Dr. Loh also was awarded the Aesculapian certificate and cash award of $200.00, donated by Mead Johnson Laboratories)

Award No. 2—J. William Wright, Jr., M.D., Clifford Taylor, M.D., A. J. Miller, M.D., 1500 N. Ritter Ave., Indianapolis —TOMOGRAPHY OF THE TEMPORAL BONE.

Award No. 3—E. T. Edwards, M.D., Roger K. White, M.D., Louisville, Ky.—MULTIPLE MONITORED ELECTROCONVULSIVE THERAPY.

MEN'S GOLF TOURNAMENT

Low Gross—Boyd A. Burkhardt, Tipton
Low Net—Joseph F. Milan, Bloomington
Low Putts—John W. Luce, Michigan City
Longest Drive—James C. Brown, Valparaiso
Closest to Pin—Robert E. Longshore, Kokomo
Highest Score—Herbert O. Chattin, Vincennes

American Medicine Leads the Way*

DWIGHT L. WILBUR, M.D.
San Francisco**

I want to talk to you about public affairs and public relations. Probably all of you are aware that the AMA has announced the formation of a new Division of Public Affairs, to be headed by the former executive director of AMPAC.

Through the Communications Division and the Division of Public Affairs, both of these vitally important functions are now receiving top-level attention in our national association.

Not only the future reputation of the medical profession, not only our so-called "image," not only the esteem in which the profession is held . . . but the very existence of the medical profession as we know it now depends on our activities and our success in public affairs and all of our relations with the public.

We face the traditional and continuing challenge of ministering to every person as an individual. That hasn't changed. But added to it is the equally important, and even more difficult, challenge of ministering also to all of human society in our nation.

This is a relatively new responsibility for our profession. It is one that many of our members are not yet ready to accept; and one for which many of us are not prepared. But the successful discharge of that responsibility will influence the field of medicine as significantly in the years ahead as three outstanding movements earlier in this century have influenced medicine as of this date.

* Presented at the ISMA annual convention, Oct. 17, 1968, at Fort Wayne.

** President, American Medical Association.

Looking Backward

The *first* influence was initiated by the medical profession and activated in 1908 when the Council on Medical Education of the AMA, with the financial and technical support of the Carnegie Foundation for the Advancement of Teaching, surveyed the quality of medical education in the United States.

The results of that survey, published in 1910, are remembered and honored to this day. The Flexner Report, as it is known to us, revolutionized medical education. Because of its influence, plus the AMA's subsequent support of the establishment and strengthening of state licensing boards and the AMA's continuing, cooperative activities in the accreditation of medical schools, the medical profession played a leading role in making American medical education the finest in the world.

Our schools today attract students from virtually all nations, whereas in earlier years our students went abroad for what was then the best available medical education.

The *second* major influence has been the great advances in medical science and in the knowledge, equipment and methods today's physician uses in caring for his patient.

This is an area to which the profession has contributed much, and many others have contributed—directly or indirectly.

Let me remind you that approximately at the turn of the century, life expectancy in this country was 46 years. One of every six infants died. The principal killer diseases were diphtheria, pneumonia, typhoid and tuberculosis. There was essentially no sphygmomanometer, no x-ray diagnosis, no blood chemical tests, no specific treatment of disease, no specialization of physicians.

Elective operations were rare because asepsis, intravenous fluid therapy, blood transfusions and good anesthetics were yet to come. There were nurses, but few other allied health personnel.

It is difficult to accept that physicians of that day and this was even in the same profession.

The *third* significant influence has been the growing infusion of federal tax money and federal programs into the health field—not only in research and education, but also directly into patient care.

Government involvement in health is not new, although it has drastically changed. It began with marine societies, created for the benefit of merchant seamen by several colonies before there was a United States. That involvement has grown substantially and, in recent years, at an accelerating rate.

The 89th Congress saw 1,600 bills of medical or health interest, and passed more health programs than any previous Congress. 1,400 such bills were introduced into the 90th Congress.

In fiscal 1960, the appropriation for Federal health activities was $3.2 billion. This sum grew to $3.8 billion in 1961; $4.4 billion in 1962; $5 billion in 1963; $5.5 billion in 1964; $5.9 billion in 1965; $6.6 billion in 1966; $11.3 billion in 1967; $14.2 billion in fiscal 1968, and in the bill passed by the 90th Congress, almost $20 billion. This was almost $6 billion more than last fiscal year.

These three influences—the increasing excellence of medical education and the advances in medical science, both of which have vastly improved the quality of care provided by today's physician. . .and the growing involvement of government in programs to finance or provide health care for large segments of the population—have played significant parts in creating the over all picture of medical and health care as we see it today.

A Fourth Influence

They also have led to what I consider the fourth major influence of this century: the task of relating the field of medicine to all of society.

In the past, medicine has been primarily a personal relationship, between one physician and one patient. Public or government interest generally was limited to such public health concerns as environmental improvement, sanitation and the prevention and control of epidemics.

Not any more. Today—and even more tomorrow—medicine and health are matters of total public concern. The ready availability not just of adequate care, but of excellent medical and health care is now interpreted by government and by many among the public as a basic human right, along with life, liberty and the pursuit of happiness.

The question that now demands an answer by our profession is whether in serving all of society we shall be the leaders, as we were in revamping and professionalizing medical education. . .shall lead, but share our leadership with others, as we have done in scientific research and medical advances. . .or remain aloof, concentrating primarily on what we decide are our own interests, and expressing our disapproval of ideas proposed by others, as we have done for the most part with respect to the growing interest of government in health care.

My answer is that we must not, we cannot, remain aloof if we want to preserve the medical profession as the essential and viable profession it is today.

Not a Follower Be . . .

If we do not become the leaders, although sharing leadership with others who have a legitimate interest in health care, we shall find that in this important matter of relating medicine to society, the public will assign us a position as followers . . . and, ultimately, as subordinates.

Let us assume that a medical association wants to claim its rightful leadership position. How can it be achieved? The passage of a resolution isn't going to do the job, nor is a public announcement. Leadership is not conferred on those who merely decide they want it. Instead, it is given to those who can clearly show—by their actions—that they are qualified for it and deserve it. Leadership, at least in a democracy, is not assumed. It is earned.

I believe there are 10 points in a program of medical leadership.

Health Problems

The *first* is to become familiar with all of the health problems in the local community or state. That includes not only the kind of problems individuals have who need help, but also the kind of problems all of the personnel and institutions in the health field have in providing that help.

This means the medical profession must establish a close, working liaison and have free exchange of information with all the professional and non-professional people in the health field. Included here would be all organizations of physicians. . . dentists. . .nurses. . .technicians and technologists. . .voluntary health agencies. . .public health officers . . . medical schools. . .hospitals. . .extended care facilities . . . welfare and social service agencies. . .health insurance companies and prepayment plans. . .and, of course, the public itself—which can best be reached through its organizations, such as civic clubs, fraternal organizations, women's groups and churches, as well as all levels of government plus industry and organized labor.

Through cooperation with all of these forces, the medical profession can show its genuine interest in the availability of care for all citizens and in breaking down any barriers between people and the care they need. The best means for establishing such cooperative efforts are through the participation of the profession in initiating or effectively assisting in the development and function of planning bodies, councils, committees, at the local, regional or state level. Local people are most familiar with the local situation and with local needs.

Our leadership must be cooperative and not dictatorial. Our knowledge of health may be unique and indispensable, but our desire to serve all of society is matched by many of its other elements.

Legislation

Second, we must devise desirable legislative programs and work to get them enacted. We must participate in the legislative process at every level of government, from city hall to Congress and the White House, in the planning and administration of health laws and regulations. In doing so, we must keep in mind the best ways to meet the needs of the public for the benefits of physicians' services and other forms of health care that are available.

It is vital that we help everyone understand the often wide difference between actual need and demand for what is desirable. If this distinction is not made, it can lead to highly emotional situations that result in precipitous political action to solve impossible problems which are inordinately expensive.

Continuing Medical Education

Third, we must play a more active role in maintaining high standards

of quality in medical practice, particularly by urging physicians to participate in continuing medical education. Certainly this is a kind of leadership that the public expects of us. It will help answer the growing interest in relicensure or reaccreditation of physicians.

At the national level, the AMA has long recognized the importance of continuing education of the practicing physician and has contributed substantially through scientific meetings, scientific publications, national conferences and, now, a program of accreditation for continuing education courses offered by a variety of institutions.

At the annual convention in June, the AMA House of Delegates approved a proposal by the board of trustees that a mechanism be established to recognize formally physicians who participate in continuing medical education. More details of that plan will be discussed at the clinical convention in December.

Medical Care Costs

Fourth, we need to better understand and to assume the proper responsibility for the costs of medical care and to increase our concern for expenditures for hospital care.

Just as we have prime responsibility for the costs of our services in hospitals, so must we increase our concern with the economic factors in hospital costs. We must see that physicians become members of boards of trustees and directors of hospitals and become more knowledgeable of the cost to their patients of hospital services. I believe it would be very helpful if every physician received a copy of the hospital bill of his patients so he would be aware of the costs to them of hospital services and of the professional care he had ordered.

We must recognize and tell the public honestly and frankly that for some time health care costs will continue to rise. . .and tell them why. Increasing wages of hospital employees including nurses, house staff and non-professional groups, inflation, etc. Inflation, growing population, greater demand by more patients, more expensive facilities and higher trained personnel, higher costs of personnel and payment for services by third parties—either private or governmental—doubtless will raise the cost of health and medical care in the future.

It is generally understood that automobiles and all other goods and services cost more as they are refined and improved. We ought to be able to show people that the same is true for essential services and necessary facilities for health care.

At the same time, we must try to hold down our patients' expenditures by making use of hospitals only when clearly necessary and by encouraging the development of more extended care facilities, better insurance coverage for more home care services, for out-of-hospital services including prescription drugs, along with all the other things we can do to help save money.

The charges for professional services and the gross income of physicians will increasingly come under public scrutiny. Here we must recognize the concern of the public, the government, employees, labor and others. A sound approach on the basis of the usual, customary and reasonable charges for services, with peer review when necessary, seems the obvious, mature and sensible approach to this difficult problem, which may indeed be the vulnerable point in our efforts to avoid a fixed-fee schedule and arbitrary decisions of those outside the profession to control it effectively.

Medical Ethics

Fifth, in order to prove not only our good intentions, but the real excellence of today's medical care, we need to concentrate more attention on adherence to medical ethics by our colleagues . . . to utilization review by physicians of the use of health care facilities. . .to peer review. . .and discipline by the profession of members who do not measure up—not just to the level expected by the public, but to the higher standards we set for ourselves.

Supporting Research

Sixth, we must continue to advance our knowledge of the causes of major illnesses. Our profession can play no greater role in the health betterment of today's people and of generations to come than by generously supporting research that will expand the profession's ability to diagnose and to cure disease and prevent it.

Expansion of Medical Schools

Seventh, we must help generate support from individuals, business, labor, government and all other sources for the expansion of medical schools and the establishment of new ones, where necessary, so that eventually every qualified applicant for medical education can get it.

I believe every practicing physician should contribute at least $100 a year to the AMA-ERF for medical schools or give directly to the medical school of his choice. This would bring $20 million a year to our medical schools—a great boon to medical education and a clear indication to industrial, corporate, foundation and individual contributors that we in the profession are vitally interested in supporting medical education, and in expanding it. Since this contribution is tax deductible, the actual amount given would often be significantly less than $100.

Similarly, we must encourage quality education for larger numbers of men and women in all the allied health professions and services.

Insurance

Eighth, we should demonstrate the effectiveness of the private system of medical care and of the voluntary health insurance and prepayment mechanisms. We must make

them more effective, more widespread, more comprehensive and as economical as possible.

Particularly, we should continue our efforts to achieve wider insurance and prepayment coverage outside of the hospital, in the physician's office, home, or in extended care facilities. . .and of additional items such as prescription drugs and private duty nursing.

Government financing is clearly not the answer to problems involved in covering health care costs. But in order to assure that the voluntary system is the answer, we must work with carriers to make health insurance and prepayment increasingly effective, efficient and comprehensive.

Collect Facts

Ninth, we must collect the facts on the economics of medical practice and of all health care so that we become the recognized experts in this field.

Little is known now, for example, of variations in the economics of health care provided by the solo practitioner . . . the group . . . the specialist . . . the generalist . . . the hospital-based physician . . . the physician in a large city . . . and the physician in a rural area.

Nationally, I hope to see the American Medical Association become this nation's bank of information on every aspect of health care economics. At the state level, each state should have a similar responsibility.

Remain Free Leaders

Finally—number *ten*—whatever activities we undertake, we must remain free. We must be and act as a profession, and not become a group of technologists. We must guide our destiny, and not be guided by others. We must lead, and not be led.

Cooperation with others in planning for health care does not mean compliance with the plans of others that would harm the patient by dehumanizing the care that is to be made available to him.

Whether we are family physicians or specialists in a narrower field, each of us must maintain the strength of the physician-patient relationship that is so much a part of successful medical care. No plan for providing care can be good if it weakens or eliminates that relationship.

As physicians we have learned that we treat not just a disease, but the whole patient. We are now learning that as we view the individual, we also must see the group of which he is a part.

In other words, as I indicated earlier, we minister not just to the man, but to society. I accept that, as all of us must. But through it all, we must never overlook the individuality of the patient and of the physician. Both must be preserved.

Achieving These Ends

Accomplishment of these aims will not be easy. Although each of them obviously is well within the profession's area of competence, none will likely be reached without some opposition from agencies, organizations, groups or individuals with whom we are trying to cooperate.

To undertake a program, or package of programs this large, the association will have to count on the dedicated efforts of many of its members.

It will mean the enlargement of the staff of our local, state and national associations. It will probably mean an increase in dues. But the dividend that will flow to the American and to our profession as we implement and enlarge our responsibilities to the public, will be greater than the slight cost to us in dollars.

One very special group must be assigned to coordinate and oversee the entire leadership project. This can be the existing board of trustees or directors, or it can be a special committee appointed for that purpose. It should include participation by younger physicians in the society.

The association as a whole, if it wants to accomplish objectives as vast as those I have outlined, will need an over-all attitude of leadership, not by a few members, or by the officers, but by the entire membership, in their own practice and in association activities.

As we enter this era of fateful developments for the health of our country and its people, as well as for the future of our profession and it services to the public, let us focus on directing the course of the future. We must do this by planning . . . by being prepared . . . by turning unexpected developments in the direction of progress. . .by fostering high quality medical care . . . by developing broadened availability of it . . . and by carrying out all of the other activities I have talked about plus the many more that will occur to you and to other associations who undertake this exciting responsibility.

We must also invigorate the growth of our profession by increasing our numbers and by motivating our young members and passing on to them a bright and unflickering torch of devotion to human service.

We are among the most privileged of men to have this challenge, this opportunity to direct the course of human destiny and improve the course of human welfare.

Let us assume the challenge with confidence and true statesmanship. ◄

Association News

EXECUTIVE COMMITTEE

October 14, 1968

Meeting called to order at 10:00 a.m. by the chairman, Dr. Ralph V. Everly, in the Chamber of Commerce Building, Fort Wayne, Ind.

Present: Ralph V. Everly, M.D., chairman; Burton E. Kintner, M.D., G. O. Larson, M.D., Patrick J. V. Corcoran, M.D., Lowell H. Steen, M.D., Lester H. Hoyt, M.D., M.O. Scamahorn, M.D.

Frank B. Ramsey, M.D., editor, *The Journal*, James J. Stewart, attorney, James A. Waggener, executive secretary.

Guests: Antonio B. Donesa, M.D., Hanus Grosz, M.D., Felix Millan, M.D., Wei-Ping Loh, M.D., August Tomusk, M.D.

Minutes of the September 19th meeting were approved on motion of Drs. Kintner and Larson.

Membership Report

Number of members as of December 31, 1967	4,422
Number of members as of September 30, 1968:	
Full dues paying	3,895
Residents and interns	110
Council remitted	60
Senior	304
Honorary	2
Military	55
Total 1968 members as of September 30, 1968	4,426
Number of members as of September 30, 1967	4,392
Gain over last year	34
Number of AMA members as of September 30, 1968	4,272
Number of AMA members as of September 30, 1967	4,223
Gain over last year	49
1968 AMA members:	
Dues paying	3,749
Exempt but active	523
	4,272
Number who have paid state dues but not AMA dues as of September 30, 1968	154

Headquarters Office

The secretary gave quotations on the telephone recording system and on motion of Dr. Steen and taken by consent, this matter is to be placed on the November meeting agenda and the secretary is instructed in the meantime to obtain information on this equipment for leasing rather than purchase.

A brief report on the membership survey was given for the information of the committee.

Treasurer's Office

The treasurer's report was approved on motion of Drs. Hoyt and Larson.

Organization Matters

The committee then discussed the National Association of Foreign Medical Graduates with Doctor Donesa and other guests who explained the purpose of the organization. The Executive Committee expressed an interest to the group in their program and wanted them to feel welcome at any time to bring their problems and ideas to the attention of the Indiana State Medical Association.

Renewal of membership in the Indiana Conference on Social Welfare was approved on motion of Drs. Steen and Kintner.

A resolution regarding establishment of the American Board of Family Practice adopted by the North Carolina Medical Society was reviewed for information of the committee.

A letter frrom Dr. Herman Wing announcing his resignation as an alternate councilor from the 10th District was read for the information of the committee.

A letter from Dr. Merritt O. Alcorn, president of the Board of Medical Registration, addressed to Dr. Schuster, chairman of the Commission on Legislation, concerning the establishment of the FLEX examination in Indiana, and the necessity of raising examination fees was read for the information of the committee.

A letter from the AMA stating they were considering the appointment of Dr. Neal E. Baxter for membership on the Council on Occupational Health was reviewed and the AMA is to be informed of ISMA approval. This was taken by consent.

A statement which has been prepared concerning pronouncing death was reviewed and this matter, on motion of Drs. Larson and Steen, is to be referred to Mr. James Stewart for his review and report.

A letter from Dr. Karlick addressed to Mutual Medical Insurance, Inc., was read for the information of the committee and on motion of Drs. Hoyt and Steen, this correspondence is to be referred to the Council Liaison Committee with Blue Shield.

The action of the Louisiana State Medical Society concerning direct billing under the OEO program was reviewed for the information of the committee.

The "Report to the President" by Wilbur Cohen was reviewed and by consent it was agreed that this should be reproduced and sent to the Executive Committee and members of the Council.

A letter addressed to Dr. Larson from the AMA urging cooperation of the Indiana State Medical Association with the Indiana Academy of General Practice and a branch of the American Psychiatric Association concerned with continuing psychiatric education for physicians was reviewed for the information of the committee.

The report from Mr. Stewart concerning his attendance at the Medical-Legal Conference was reviewed and it was requested that this report be reproduced for information of the committee and the Council.

A request from Dr. Haymond concerning a representative of the association to meet on October 23rd to discuss the Autopsy Code was discussed and Dr. Hoyt volunteered to attend this meeting.

Annual Convention—Fort Wayne, October 15-18, 1968

The program for the 119th annual convention and a report on the sale of exhibit space was reviewed. On motion of Drs. Steen and Larson, the headquarters location and the dates of the 1969 meeting were referred to the Council for their approval.

The address of the president was reviewed and on motion of Drs. Steen and Hoyt, was approved.

Future Meetings

An invitation to attend a meeting to be held by the Indiana State Chamber of Commerce on the subject of Medicaid on November 19th at the Atkinson Hotel in Indianapolis was reviewed and on motion of Dr. Steen and taken by consent, the president, the executive secretary, and the legal counsel were authorized to attend this meeting.

The AMA Conference on Continuing Education to be held in Chicago at the Palmer House on November 12-14 was reviewed and by consent, the president, the president-elect, with the chairman of the Commission on Medical Education and Licensure were authorized to attend this meeting.

The meeting of the AMA Conference on Community Health Planning to be held at the Statler Hilton Plaza Hotel in Miami on November 30th was reviewed for the information of the committee.

A request of the I.U. School of Medicine for a joint meeting between the Executive Committee, the Council and the Alumni Association was reviewed and on motion of Drs. Steen and Corcoran, the Executive Committee agreed to accept this invitation

and to refer this matter to the Council for their concurrence.

There being no further business, the committee adjourned to meet again following the organizational meeting of the Council at the conclusion of the final meeting of the House of Delegates on Friday, October 18, 1968. ◄

EXECUTIVE COMMITTEE

October 18, 1968

Meeting called to order in the Women's Club, Fort Wayne. Roll call showed the following members present:

Ralph V. Everly, M.D., chairman; Burton E. Kintner, M.D., Patrick J. V. Corcoran, M.D., Lowell H. Steen, M.D., Donald Taylor, M.D., Lester Hoyt, M.D., M. O. Scamahorn, M.D.

James Stewart, attorney, and James A. Waggener, executive secretary.

By secret ballot, Dr. Ralph V. Everly was elected chairman of the Executive Committee.

There being no further business, the committee adjourned to meet again at 4:00 p.m. Saturday, November 16th. ◄

THE COUNCIL

August 17, 1968

On the call of the Chairman, Dr. Lowell Steen, the Council convened at the headquarters building at 7:30 p.m. Saturday, August 17, 1968.

The roll call was recorded as follows:

District Councilors:

1 Absent—Gilbert M. Wilhelmus, Evansville
2 Present—Joe Dukes, Dugger
3 Present—Donald M. Kerr, Bedford
4 Present—Robert M. Reid, Columbus
5 Present—Wilbert McIntosh, Riley
6 Present—Stephen D. Smith, Knightstown
7 Present—Albert M. Donato, Indianapolis
8 Present—Donald R. Taylor, Muncie
9 Absent—Peter R. Petrich, Attica
10 Present—Lowell H. Steen, Hammond
11 Present—Lowell J. Hillis, Logansport
12 Present—William R. Clark, Fort Wayne
13 Present—Otis R. Bowen, Bremen

District Alternate Councilors:

1 Absent—Eugene W. Austin, Evansville
2 Absent—Betty Dukes, Dugger
3 Absent—E. L. Wallace, New Albany
4 Present—Jack E. Shields, Brownstown
5 Absent—C. M. Schauwecker, Greencastle
6 Present—Frank H. Green, Rushville
7 Absent—John O. Butler, Indianapolis
8 Absent—Paul W. Sparks, Winchester
9 Present—Clarence G. Kern, Lebanon
10 Absent—Herman Wing, Gary
11 Present—James A. Harshman, Kokomo
12 Present—Frederic L. Schoen, Fort Wayne
13 Present—G. Beach Gattman, Elkhart

Officers:

Present—G. O. Larson, president
Present—Patrick J. V. Corcoran, president-elect
Absent—Lester H. Hoyt, treasurer
Present—Malcolm O. Scamahorn, assistant treasurer

The Journal:

Frank B. Ramsey, editor, absent

Executive Committee:

Absent—Ralph V. Everly, chairman
Present—Burton E. Kintner, member

Staff:

Absent—Ralph Hamill, attorney
Present—Robert J. Amick, field secretary
Present—Howard Grindstaff, field secretary
Present—Kenneth W. Bush, administrative assistant
Present—James A. Waggener, executive secretary

Chairman Steen expressed his appreciation for the members giving up a Saturday night and a Sunday to deliberate on the important problems facing the association. He announced that the meeting on Sunday morning would begin promptly at 9 o'clock and the building would be open at 8:00 a.m. Doughnuts and coffee would be available for members of the Council.

The minutes of the meetings held May 18, 19 and June 9 were approved as printed on motion of Dr. Larson and seconded by Dr. Dukes.

Reports of Councilors

The chairman called upon the councilors for reports from their districts.

District 1—No report.
District 2—No report.
District 3—No report.
District 4—No report.
District 5—No report.
District 6—No report.
District 7—No report.
District 8—No report.
District 9—No report.

District 10—It was announced that Dr. Herman Wing, alternate councilor, had moved from Lake County to Chicago, Illinois.

District 11—Dr. Hillis announced that the 1969 meeting of the 11th District would be held on the third Wednesday in September at the Delphi Country Club. He also reported on the semi-annual meeting of the Wabash County Medical Society.

District 12—No report.

District 13—The councilor reported the meeting would be held on the 11th of September at the Lantern near Michigan City. The program in the afternoon would feature a speaker from the AMA on AMA activities, one from the Washington office of the AMA reporting on Congressional activities, and the Executive Director of AMPAC to discuss the political activities of physicians in the country. This would be followed by a dinner with the dinner speaker being Mr. Calvin Johnson, director of public relations of the Remington Rand Corporation.

Unfinished Business

CHAIRMAN STEEN: We will now receive a report on the Group Insurance Program. The secretary reported the chairman of the committee was not present and he knew of no report at this time.

We will receive the report on the In-Hospital medical coverage of the ISMA Group Plan with Blue Cross-Blue Shield. Dr. Kerr requested that this matter be deferred until the Council meeting prior to the opening of the House of Delegates.

Now, we will go to item three, Dr. Larson's thirteen points. I think it only appropriate that since the president presented these points that we should call him to the podium and permit him to read the points one by one. We will deliberate and make appropriate decision on these points held over from the meeting in Washington.

DR. LARSON: Mr. Chairman and gentlemen of the Council:

"1. I believe that most of us believe that there is a shortage of medical personnel in our state. If so, I believe then that it is up to us to take a strong position in favoring the establishment of a second medical school in our state and to de-

fine its location where we believe it will attract more students and afford good teaching material. If we feel this is the solution, then no longer do I believe we can afford to take a less than strong positive position in this area."

DR. STEEN: Now this first point reiterates a position taken by the Council and by many county societies in this state, that the second medical school is essential to the state of Indiana. It is my personal opinion that much of the difficulty during the last legislative session arose from the fact that the medical profession in our state was fragmented as to where this second school ought to occur. It is my personal opinion, and I say this quite honestly to you that there are those in Lake County who disagree with me, but I don't think it is really important where the school is. But I think we ought to be willing to offer some leadership and some guidance to the legislator who after all makes the final decision about this subject as to where the school ought to go.

I personally think that we ought to make the case so strong that there is no doubt in their mind or whoever may be the next governor . . . there is no doubt in his mind, and where the foremost experts in medical education, namely the medical profession, where the next school should go. Now, I think Dr. Larson has brought to our attention here the point that we have already established—the fact that we do need a second school and we now need to take the strong position about where it goes. The subject is open for discussion and I would hope that we don't arrive at the solution hastily and without due consideration, and I would hope that this is a free and open discussion; we may delay this several times before we reach a decision, but I hope we have something positive to report to the House of Delegates in October. Dr. Hillis.

DR. HILLIS: Mr. President and gentlemen, in the past few weeks I have had occasion to visit the state of Washington and the University of Washington. During that time I was privileged to attend several of the seminars, to be a visitor to some of the conferences of the intern and resident programs, the teaching programs in the university and with King County Hospital, which is part of the teaching institution of the University of Washington. And as I sat in those meetings I wondered, and this is what I am asking now—what is the attitude, what are the statistics of our local I. U. School of Medicine? How many interns and residents are there at I.U., the Veterans Hospital and the Marion County General Hospital, who are from the state of Indiana? And how many of these are we retaining in Indiana after they graduate?

I think there should be an investigation of some sort, a study made of the internship and residency situation at the University Hospital and Marion County General Hospital to see what the possibility is of retaining part of those people in the state of Indiana. I think this is a real important study that should be conducted before we go on—I would like to know how many people there are in the teaching program at Indiana University who come from outside the state; I think this is very important to us.

DR. CORCORAN: Mr. Chairman, in connection with Dr. Hillis' remarks, we had a meeting here of the liaison group with the medical school officials about a month ago, I guess, and I threw out at that time this suggestion. As far as I am aware, there is no data available on the influences which persuade the young men first of all to enter the health profession. And parenthetically, I have a number of colleagues who are disturbed that their own sons or members of their family are not attracted to going into this work. Secondly, there isn't any good assessment of the influences which come to bear on the student in the medical course.

Reflecting from what he may have originally started to do, what are the factors that change them if they do? And finally, in graduate education, what things persuade men to veer into another direction? Or to stay constant in what they are doing? I suggested to the dean and to the professor of medicine that possibly this would be a very useful undertaking, but I personally didn't believe that it should be done by the faculty of the school. Nor should it be done by us who are professionals. But certainly the university, I think, would have the facilities and the talent to do this with our assistance and the faculty assistance in whatever way would be desirable.

I have since passed this on to one of the trustees of I.U. I don't know if this is valid, but I think this is one way of discovering what we are talking about. What is the problem? What gets people into it? What keeps them in it, what changes them when they are in it?

Secondly, there are different approaches to this second medical school. We were given the idea that I. U. was now receptive to a two-year feeder plan. Now I didn't get clear whether the two years were to be the first two years of medical school or the first year and the fourth year away from the campus. But I think this concept has been thrown out. Well, again, there is another diversion that we can take into consideration which makes it hard to come to a decision.

This governor's commission for post-high school education, I think is the name of it, has held, I believe, two hearings—one in Indianapolis. I see newspaper accounts of that, and much of the attention was given to the medical school. They had a hearing in Evansville, I attended it, but I surreptitiously avoided making any comments in my role as an officer of the association. I think some of my colleagues have learned that you can't speak and disassociate yourself from having it thought to be a public pronouncement of policy, and I think we should continue to avoid entrapment into that situation and not give the appearance of enunciating dogma from the state association until we know what it is. Thank you.

DR. STEEN: I would also like to comment that this commission held a hearing in Lake County at the Holiday Inn in Hammond on the 14th day of August. I also attended and listened intently and was called upon on three occasions to comment insiduously. I avoided comment so as to not be misquoted, although I was well fortified with the state association position upon medical education in Indiana, which has favored a second school upon three or four different occasions. Dr. Dukes?

DR. DUKES: I was informed by Harlan English, who is a member of the Illinois State Licensing Board that anyone going to a state supported school in Illinois will be required to stay in the state of Illinois five years following graduation.

This was discussed by Dr. Steen, Dr. Corcoran and others. It was finally concluded that they believe the program in the state of Illinois has twenty seats available in their medical school through the Farm Bureau and if the Farm Bureau pays for the medical student's education, he in turn agrees to spend five years practicing in rural Illinois.

Dr. Hillis raised a question as to the policy of the I.U. School of Medicine of retaining graduates of I.U. through their postgraduate, internship or residency programs. He inquired as to whether the university was seeking students throughout the country to complete their training in Indiana. Doctor Hillis commented further he felt such a study would be necessary to determine their policy.

DR. STEEN: I think your point is well taken and I think it might be well to appoint a committee to investigate this.

DR. KERR: I would like to propose this, rather than get into this kind of thing which obviously has all sorts of extraneous

influences—what do we need in Indiana and what do we have to do to get it? Now, if it takes five medical schools to retain for Indiana the people we need to practice in Indiana, well I think this is the way we have to go. We have to consider socio-economical, geographical, climatical, etc., factors. Because everyone who has talked about these things say they are important. Now, if we need no more than what we have to supply Indiana, considering all these factors, let's forget it. And if we need five times as much, then I think we must consider this, considering that we will lose X number of people and we will.

Discussed by Drs. Clark, Taylor, Bowen, Kerr, Schoen, Dukes, Harshman, Scamahorn, Reed, McIntosh, Corcoran and Gattman.

DR. LARSON: Gentlemen, your remarks are greatly appreciated. It so happens that I have been very interested in this subject. I have followed everything which the Legislative Study Commission has made public. I have talked with a number of the members of the Legislature in the last session. I have read completely twice the President's Medical Manpower Report.

It is my considered opinion that unless the medical profession in the state of Indiana renders some help in the next session of the Legislature, that by the time the next Legislature ends, they will be in exactly the same position they are in at the present time. I believe that to be true. I believe also that not only do we need a second medical school but we are a number of years behind already, and if we don't help to resolve this situation, instead of being ten years behind at the end of the next session of the Legislature, or the next two years beyond that, we'll be twelve years behind.

Therefore, Mr. Chairman, I would suggest that the chairman of the Council be authorized to appoint an Ad Hoc Committee to study this matter and all the recommendations that have been made by the special Legislative Study Commission at the last session of the Legislature and work with the next session of the Legislature in an attempt to solve this problem. Thank you.

DR. STEEN: Mr. President, I think that is an excellent suggestion, and if it is in accord with the Council's thinking, I will appoint such a committee at this time. The Council is in agreement and Dr. Kerr so moves by consent. I will appoint Dr. Taylor as chairman of the Ad Hoc Committee, and I would urge Dr. Taylor to call this committee into session as frequently and as often as it is necessary to accomplish the stated goal as quickly as possible, with due consideration to the gravity of the facts. I should also like to appoint to this committee, Dr. Wilhelmus, Dr. Reid, Dr. Harshman, Dr. Schoen, and Dr. Donato. Dr. Larson, point No. 2.

> DR. LARSON: "2. I think most of us down deep in our hearts realize emergency room care is far from perfect in our state. How can this problem be resolved? Either we must develop a profession that is going to handle emergency care in the home, or at the scene of the accident, or plan and develop and educate people on the proper use of emergency rooms strategically located throughout the state."

DR. STEEN: Before we open this subject to discussion, I think it only fair since we have a committee chaired by Dr. Hillis of Logansport, that we first hear a statement from him on the progress of the Council Committee on Emergency Medical Services.

DR. HILLIS: I would comment that I have had some contact with the State Highway Commission only in the way to probably start some sort of program of so called "Trail Blaze" signs indicating a location for emergency medical service. I would like to ask Dr. Fred Schoen of Ft. Wayne to speak on behalf of Dr. John Farquhar who has done a tremendous job in Allen County.

DR. SCHOEN: Allen County felt this was a very serious problem. We felt we wanted to know exactly what our situation was in Allen County as far as emergency medical services were concerned.

Four months ago we formed a Community Emergency Medical Services Council to make a study of what our situation was. We invited every organization within the county to cooperate in this study and, with the exception of one or two areas, had excellent cooperation. We started out with the medical society; we went through all of the police, sheriff's department, the state police; we went to the fire department; we went to every hospital in the county, and we went to every organization that could possibly be interested in this, including industry.

We made a complete study of the emergency medical services from the highway department down to the emergency medical services within the hospital. We published a report of the study of Fort Wayne/Allen County Emergency Medical Services. It came off the press yesterday. The purpose was to present a coordinated summary of all of our services. What were we doing? What were we doing wrong? Where could we improve ourselves? And believe me, we were critical of ourselves. This book is a complete summary of Allen County emergency medical services.

We have immediate and long-range recommendations for improvement where the services are concerned. We have been criticized by the newspapers, not only as physicians, but our police department, sheriff's department, our ambulance services, have been criticized. We have been critical of ourselves. We have come up with what we think are recommendations to improve ourselves and our emergency medical services. I think that the state medical society could well start a study on this basis. I think all of us recognize that there are defects, that there are emergency medical problems varying from the problems in Indianapolis down to the problems in a very small community. I think we in Allen County have given you something to work from.

I would like to submit this to the state medical society for possible implementation by the Council Committee on Emergency Medical Services during the following year. This is the only copy I have left. I'll pass it around the room. You can look at it. It is a very serious study; we have gone through this thing from the ground up, and we have made recommendations that I think would help statewise.

DR. STEEN: Would it be possible to obtain sufficient copies of this material for all the councilors?

DR. SCHOEN: They are to be mailed this week and I believe they are in the mail now to all councilors.

DR. STEEN: As chairman of the Council, I would like to thank Dr. Hillis, chairman of the Emergency Medical Services Committee— your committee has done a heroic job. I would somehow like to get a report of all these Council committees which have done a great deal of work during the last year before the House of Delegates so that we can either get some commendation for what we have done and some impetus to proceed with what we are doing or some direction as to how to proceed in a different direction, if that is the feeling of the house.

DR. STEEN: Now Dr. Larson has something very important to report to you about item 3; an accomplishment has been achieved as the result of this recommendation.

> DR. LARSON: "3. We have been, over the years, and still are, conservative. We have taken the position we can do the job without federal interference or without outside influences. However, as the period of inflation strikes us, we find if we are going to tackle many of these responsibilities, it requires money. Therefore, I

would suggest that we would consider the establishment of a nontaxable, charitable foundation for receiving and disseminating funds for use in health education and health care purposes. Think seriously about that."

Gentlemen, it is with a great deal of pride that I inform you tonight that there is in existence at the present time such a foundation. I would like to call on our secretary to give us a brief rundown as to what the Executive Committee has done and outline to you some of the things which the foundation can do.

MR. WAGGENER: Gentlemen, you may remember several years ago Dr. Frank Ramsey, editor of *The Journal*, brought up the question of a foundation. Dr. Ramsey pointed out that not having a family, that he and maybe other doctors might like to have such a foundation to which they could leave their estates. The purpose at that time was to set up a foundation for the continuing operation of *The Journal* and for furthering the purposes of other activities of this association.

As a result of this, and the president's recommendation, Judge Ralph Hamill has drawn up a foundation in consultation with Dr. Ramsey. The foundation is very broad as to what uses may be made of the funds received and how funds might be left to this foundation. The final report was presented to the Executive Committee, it was approved by the Executive Committee and a total of $106.00 was collected from those around the table to place the foundation in operation. These monies were entrusted to the treasurer of the association, Dr. Hoyt. The foundation papers were filed as of July 26, 1968 and the corporation is now legally in existence. The formal name is Indiana Medical Foundation, Inc.

Discussed by Drs. Kerr, Taylor, Larson and Corcoran.

Dr. Larson then read Point #4.

"4. With the growing demand for medical care, should we study the use of medical assistance on the basis similar to the corpsmen set-up in the armed services?"

DR. LARSON: Does anyone have any comment to make on this point? This question has been raised many times.

Dr. Larson then read Point #5.

"5. I believe that we must work more closely with voluntary health organizations and allied health groups in working out some of the problems that our public seems to think exist. If we are to do a good job in comprehensive health planning then we must work closely with these people, as I see it."

Dr. Larson then read Point #6.

"6. We should make an intensive study of the number of doctors needed for a certain number of individuals in a particular area, in order to make readily available first quality health care."

DR. LARSON: I think perhaps this subject has had enough time devoted to it already this evening unless some one of you wish to comment further. There being no further discussion, he continued reading Point #7.

"7. I know this is controversial but nevertheless I think we must study it and that is . . . are there benefits to be derived as far as public health care is concerned, through group or confederation type of practice?"

DR. HARSHMAN: I would like to ask a question. I noticed that in many reports that are coming out that the answer to increased medical cost is health groups—doctor groups. Now I would like to ask, is there a decreased cost in health groups or have there been any studies done which indicate that there is less cost to a patient in a group practice than in a private solo practice? Have there been any studies done?

DR. SCHOEN: There have been a lot of studies done, and I think the thing you are missing is the thing the government is pushing—they are talking about prepaid group practice (capitation, right). They are not talking about group practice as is. Now if you talk about prepaid practice—yes, there are savings. They can put a cap on what is spent. But when you are talking about group practice, you are not talking about prepaid practice.

DR. HARSHMAN: We are not talking about group practice as is today. You know it is a little misleading.

DR. TAYLOR: You will notice in this thing that was mailed to you on this Conference on the Cost of Medical Care, Cohen's comments all centered around group practice on a capitation basis. This is a thing that is not widely known. This is what they are pushing for. Most of us think of group practice as a multi-specialty group of several men of a given specialty practicing together on a fee for service basis. But this is not what HEW is talking about.

DR. LARSON: Yes, I think Doctor, that the point you make is very well taken. The public in general does not understand what is meant by the literature and publications that are put out by HEW as far as group practice is concerned either. Any other comments on this point?

Dr. Larson then read Point #8.

"8. One of the provisions of the law deals with traffic safety. I think we must give serious thought to this area of health care as it relates to the physician."

DR. LARSON: I think we must give serious thought to this area of health care. Gentlemen, I am going to ask that we defer this because a little later on in the agenda I will have something to present to you on this question.

Dr. Larson then read Point #9.

"9. We have been fortunate in not having many serious disasters but is the profession adequately prepared for a disaster which may arise at any given time?"

DR. LARSON: I think this is something we need to give thought to. I suspect there are many communities where perhaps they are not adequately prepared to handle disasters, small or large.

Discussed by Drs. Gattman, Kerr, Harshman and Taylor.

Dr. Larson then read Point #10.

"10. Perhaps one of the areas to which we should give very serious thought and searching study, is the area of medical education. Does a physician need further training before entering private practice or should we determine if we can lower the standards of qualifications for entering the schools of medicine and thereby bring more men into the field rather than utilizing foreign trained physicians?"

DR. KERR: Comment one, I don't think we should get, and I said this in the last House of Delegates, into a situation where we are in a program of condemning the foreign trained physician if he is qualified. Comment two, if the medical curriculum as of now involving the years that are involved to supposedly qualify a man to go and practice medicine, if this curriculum is not adequate to qualify them, then that curriculum should be charged instead of lowering standards or increasing years.

DR. DONATO: I might make two comments about the procedures so far. I think this one pertains to the number one group that we started to spend so much time on. Standard qualifications for entering the school of medicine mean so many things . . . are you talking about the point average of the individual or are you talking about the overall individual who has a nice personality. He has a C+ average instead of an A average; he's a nice guy, he wants to work, he's a hard worker, he's a small town boy who wants to go back and practice in a small town—yet he can't get into medical school because he doesn't have a straight A average. This

is a very strong comment that I wanted to make on number one that I think the Admissions Committee on the university out here is very remiss in its duty in trying to get the proper type of man in our medical school. The last point I would like to make is a study of Comprehensive Health Planning. The organization of those committees require and request that they take up every one of these subjects. Every one of them. So every man on the committee will be qualified one way or the other to discuss any one of these individual points. So I think if we can stimulate the physicians to participate on these comprehensive committees, then you are going to have every one of these points represented in discussion.

Discussed by Drs. McIntosh, Steen, Kintner, Kerr, Bowen and Harshman.

DR. STEEN: Gentlemen, I would say to you that we have two mechanisms existing now to accomplish this, number one—Council meeting with the dean or the associate dean. I often think we are much too kind to them in the type of questions we ask, and we are often too polite in not getting to what we mean. We skirt about the question we want to ask and we couch these questions in terms that are designed to be polite, gentlemanly, etc. If we really want to know, I think we have to put on the brass knuckles and get down and ask them what we really want to know and challenge the statements that they make and ask for facts and figures.

Secondly, you have the Liaison Committee with the School of Medicine and to the best of my knowledge, it has met once in the six years I have been a councilor. It met a few weeks ago and had a very illuminating discussion with the dean, Dr. Stonehill, the associate, Dr. Hickam and some others, and I think we ought to refer this entire item 10 to the liaison committee to get down with them and have some meaningful discussion about admissions.

DR. TAYLOR: I was just going to ask that it might be appropriate for us to present a Council resolution to the House of Delegates requesting the ISMA be represented on this committee.

DR. STEEN: Dr. Taylor moves that the Council present a resolution to the House of Delegates of the ISMA indicating that we believe representation from the ISMA should be on the Admissions Committee on the I.U. School of Medicine. Is there a second? Dr. Kerr? Further discussion?

DR. BOWEN: Should it not be pinned down a little bit further than that because the medical school people are also representatives of the association, that they should be practicing physicians?

DR. STEEN: I think we will make an editorial change to Dr. Taylor's suggestion saying that practicing physicians representing the ISMA be represented on the Admissions Committee.

DR. KERR: Could we have someone selected by the president of the association?

DR. STEEN: We'll make a further editorial change saying "selected by the ISMA." Or do you want to pin it down to the councilor or the president? So the motion as it has now been editorially changed reads: "That the ISMA be represented on the Admissions Committee by a practicing physician selected by the Council."

DR. CORCORAN: I suggest, not because I am president-elect, but I think it should not be limited to selection by the Council but by the state association. We may decide we want to do it a different way. The House of Delegates might want to do it.

Discussed by Drs. Hillis and Kerr.

DR. STEEN: The motion hasn't been changed. No one amended the motion and unless I hear an amendment, we are about ready to vote on the motion. Those who favor the motion signify by the usual sign. In unison — "I". Opposed — silence. So ordered. Dr. Larson then read item #11.

"11. Another very important factor which I believe is essential, is the relationship of physicians to hospitals. I am sure that each of us sitting here today realizes that within the past 25 years hospitals have entered more and more into many of the areas which were formerly considered the practice of medicine. As we read and hear those who are making pronouncements in this area today, we can see the intent and the trend is to make the hospital the health center, the authority in health, with full time salaried physicians."

DR. KERR: I would refer you all to the nice little booklet that came out about the secretary's committee on the study of hospitals and medicine of today. This committee is made up of all the experts who are deans of and representatives of HEW and Puhlic Health Service, etc. This is going to be the guideline for Congress and HEW in their programs. Read it and you see exactly that this is what is intended. That the hospitals will be it. Can you stop it?

DR. DONATO: This is a very alarming subject. You can stop it in only one way—by having the backing of your own constituents—the individual doctor. We were shown that they weren't 100% interested in this backing in the failure they gave the men who wanted to do their own private billing—not being classified as hospital-connected people. If you can get to the individuals, to the doctors in the state, that they can stand together on this very, very, serious problem, then I think you can get it done. Otherwise, your question is simply answered. Unify the doctors and you can get it done.

DR. TAYLOR: Well, I think this brings up two points that I would like to discuss. First of all, we had this suit that has been lying on the docket over in Hendricks County now for some 10 or 12 months. And the second thing is this separate billing for hospital-based physicians. Sometime ago Blue Cross staff recommended to their board of directors and to the Hospital Council on Insurance that the transfer be made from Blue Cross to Blue Shield for professional coverage by radiologists and pathologists. This was turned down by the board of directors and the Hospital Association commission.

Now from the radiologist's standpoint, the people outside of Indianapolis have done a pretty good job of getting this job done. But, until we can crack one or two of the big hospitals here in Indianapolis, Blue Cross is not going to consider this on their own, and I think that this is where we as leaders of organized medicine had better get busy. I think that perhaps the president of the state association might call a meeting of some individuals. I would suggest the president of the Indiana Roentgen Society, the president of the Marion County Medical Society, and perhaps the chief radiologist of the three leading Indianapolis hospitals. We should really butt heads on this and see if we can get these people into this. It's going to have to take direct action, we can't expect these people to do it on their own. I understand that the men at Community and St. Vincent's are just not interested. But I think we are going to have to get them interested. And the only way to do it is by butting heads with them.

DR. STEEN: Can we take it by consent that we accept Dr. Taylor's recommendation? I think we all recognize that he is extremely knowledgeable in this field and has certainly been in the forefront of the battle line to have the president call such a meeting. Taken by consent. Is there further discussion of item #11? There being no further discussion, Dr. Larson, item #12.

Dr. Larson read item #12.

"12. Another area in comprehensive health planning is air pollution, water pollution and these are areas in which we have a very definitive responsibility to lend our assistance in making the air we breathe

clean and the water we drink pure."

DR. LARSON: Now this of course will be one of the important parts in Comprehensive Health Planning. Inasmuch as the hour is late, if it is agreeable, we will pass over discussion on this point at this time.

Dr. Larson read point #13.

"13. Knowledgeable as we are and with the lack of manpower, if we agree that there is a lack of manpower, then should we further sublet the practice of medicine to others? I mean by this, should we develop in nursing and in other groups the training and the authority to do many things that physician now considers his sole right? As you may well remember the White House Conference of a few years ago, in which it was pointed out we were misusing manpower, that we can train other people to do many of the things a physician now does, in order to free the physician for those services which only he can give."

DR. McINTOSH: I think we already have proper people trained—not people—we have machines trained to do most of the work. I think this is our answer rather than people. Machines are one of our timesaving things, and computers can do more for us, and I think we should be looking toward the computer age rather than looking backwards to the slave labor type thing. One computer can take the place of many, many people.

DR. KERR: I would like to ask Bob Reid to make some comments on that because I know that he has some interest in that area.

DR. REID: Well, I'm not sure that this is the time to go into this, but I have personally, as Dr. Kerr said, in the last several months been interested in what potential computerized, multi-phasic programs can do for us. I know ludicrous results that some people have had, but I think this has no bearing on the fundamental promise of this equipment.

As you know, I represent a district that has one of the most acute physician shortages in the state. It would seem, without too much imagination, one could apply some of these techniques rather immediately and rather effectively to some of our problem areas. I think the expense is not nearly as great as probably everyone of us automatically assumes, and their progression and effectiveness, particularly in history taking, has been pretty remarkable. I spent a day and a half with Dr. Lawrence Slack in Madison, Wisconsin last week, and was quite impressed with the progress that had been made there in the last six months.

I just ask you to contemplate for a moment the advantage you would have as a physician upon first seeing the patient—having a detailed accurate history—not necessarily with all the complete definite details but the basic groundwork history done. The EKG, as most of you know, can now be read reasonably accurately by machine and interpreted reasonably accurately. Other things will soon be included: the computerized laboratories are certainly very much with us right now.

If you start off with a failure, with all this advantage, your time expenditure with all this advantage is going to be considerably reduced. I repeat, we are just in the very beginning of this. With respect to how or what we can do, this offers promise in a number of areas.

We are trying to interest physicians in our activities up here. I think the kind of points we are talking about here are important ones for that kind of interest. But I know, Batesville for instance: if you can go down there next week, you can sit down with these doctors and show them how they can see more patients more effectively, you don't need any blurb to get their interest. These are things they are faced with every day, and they are going to be interested. They are not apt to take time to go to some place to study computers: they don't have the money to buy this kind of equipment.

I would just ask you to reflect a little bit on the feasibility of a standing committee to keep us knowledgeable on these technologies and what these things promise and even to think in terms of possible subsidy for the pilot studies in some of these areas for this kind of equipment. It approaches the physician shortage; it approaches some of the problems put forth by the President's Commission on Medical Manpower recently, and I think it has considerable power as a public relation gesture.

In the course of the next few weeks, I wish some of you would think about this because I really believe we are going to be appalled by the speed by which computerized medicine moves into our daily lives. It's no joke; it's here, and they are learning very, very fast. I think this is an interpreting medicine; not just a laboratory procedure and should be incorporated in the hospital. It's of interest that of those individuals who contacted Dr. Slack—I was the only private physician who contacted him relative to this. Every other request was from a group—a hospital, industrial medicine, facilities, etc. It's understandable: they have the money—the man is on salary. He can afford to go up there and take his time. We all appreciate this, but I think that this is an area that we should really jump into because it is one of the things that is clearly in the private sector of medicine. The teaching hospital possibly has some justification, but basically, this is the private physician's prerogative, and we can defend this logically against almost any kind of tactics. It fits our interpretive concept of clinical medicine. I just wish that maybe you would reflect a little bit on this and maybe we can talk about it some more.

DR. SCAMAHORN: I also want to point out that in Indiana we have two definite trends of training sub-medical personnel. Dr. Frank Lloyd did a survey of a group of people who live between Methodist and General Hospital as to the Pap smears done, the blood drawn, etc., as to why they didn't make themselves available to our free clinics. There was a great wealth of clinical material including positive serologies and positive Pap smears and all performed without the services of an M.D. This is very interesting and I think we should make cognizance of the political people in Public Health who refer to this with glowing terms about this being great medicine. I have to admit this is better than no medicine, and this is what the people were getting.

Secondly, at Evansville at Welborn Clinic, we have the first of the three-year trained, non-medical doctors who do complete physical exams and complete histories on patients and then turns his material over to a physician and works with the physician who also sees the patient on recalls. And if you hit the ceiling on this, I ask you to examine your general practice and yourselves, and remember what happens to the prenatal patient when she is scheduled for a routine checkup and you have to go back to the hospital for a routine delivery. How many times does she come back on a particular visit to see you again? Your nurse makes a clinical evaluation; you have already subletted this in your own office. I only add that to Dr. Reid's thoughts, and I add that these are some things that we as an association must be aware of and decide what directions these things will take. They are interesting.

DR. KERR: I just want to supplement Dr. Reid's statements by saying that if we do not as physicians, then you know darn well that the hospitals will and already are and the government will—in every category from the federal on down, because they see problems that we don't. We all reflect what we have in our own

community and in our own individual practice—we all see that—we happen to have blinders beyond that area. And when we say we have no problems: I think we are not seeing them.

Other people who look and see these other areas that you mentioned between Methodist and General, do get into these problems. I think Bob's suggestion of utilizing these things will perhaps eliminate some of the other people in the picture if we utilize them. We can't utilize them unless we find out what they are all about.

DR. BOWEN: I have not seen it on the state level, but I have heard discussions of it on the Federal level of the establishment or development of a new profession—the assistant doctor or whatever you want to call it, and I just imagine in the next five to ten years, you are going to be hearing a lot about that with the individual being able to apply casts, take sutures, do normal deliveries, and anesthesia, interpretation of certain laboratory tests and so forth. I think we need to be thinking about it.

DR. STEEN: I want you to know that the U.S. Navy and U.S. Army—I am particularly aware of what is going on in the Navy because in the past week I spent some time with a recently retired Navy captain who is in the state of Indiana doing some work on some other field—namely the predication and certification of medical clinics. He informs me that for about 15 years the U.S. Navy has taken chief petty officers and trained them to such a degree of proficiency that some of them are certified for independent duty on battleships, islands and other out-of-the-way facilities where they cannot possibly man physicians. These individuals do an excellent job, and they have an intensively sophisticated protocol developed to evaluate these people. They know that they do a good job and it would be my feeling that this is a reasonable area for this association to explore.

DR. REID: I would like to comment just a little bit. I was a crypt analyst during World War II—probably most of you don't know what that is—we dealt with system analysis to some degree and we were just beginning at that time to use the next step-sorters or the beginning of computers. The interesting one, particularly one in Racine, Wisconsin, has kind of been the leader in this area, and they are using a wink-aid, which is a modest computer by our modern day industrial standards—and it's an utterably simple arrangement. I think everyone of you right now would be impressed with the capacity of this thing to take both a general medical history and internal medicine history, and other special area histories. They don't have many—it is a slow process. It's going to take time, but there are only ten people working on it.

The ignorance of these people is unbelievable as far as what they are dealing with—they are far more aware of this than I am; I am not criticizing them, but they are just beginning with this. And already, the results, I think, most of us would find impressive. They haven't even touched fundamentally the computer itself: they are just playing with it, and even for myself—my quite limited understanding of systems—it's quite simple in a few hours time to see all sorts of ways you can apply these things more effectively.

They are not physicists; they are not computer experts, and this is a fertile field for the young man today because you just don't have enough people who know enough people who know about both fields yet. But I think anybody can see that this is rapidly coming. I don't think we can sit on our hands too long without taking some steps to show our awareness of it. I would say again that I wish you would give some thought to an establishment of at least an agency or whatever you want to call it to keep us aware of where we are and what the potentiality might be here and what possibly we should do about it.

DR. LARSON: Mr. Chairman, may I state this in my opinion is one of the most interesting Council meetings I ever attended. I am particularly gratified to hear the recent discussion, to hear what Bob Reid had to say and I merely offer this as a suggestion; I think it is entirely possible that we as an association should study computers as they may eventually aid the practicing physician.

DR. STEEN: Dr. Reid, if we were to establish a committee to study and explore this, because of your knowledge in this field, would you be willing and would you have the time to devote to being the chairman of this committee?

DR. REID: I would be very happy to.

DR. STEEN: I, as chairman of this Council take the prerogative to appoint you chairman of the Ad Hoc Committee to study this problem and give you the privilege of selecting the other four committee members you would like to have work with you. May we take that by consent? Taken by consent. Thank you, Dr. Reid, for taking this assignment; it is an honorous one and I think this will move us ahead in a field that is very important. I think we all recognize that this may be a single event that may make us unite. Now this concludes the discussion of Dr. Larson's thirteen points, and I want to make two announcements.

I want to remind all of you who have not yet complied with the Constitutional requirement, and I don't know really if there are any or not, that your councilor reports were due in the headquarters' office on August 1st. If you have not submitted them yet, I would ask that you make an effort to get them in before the end of the week-end. Any report is better than no report.

We now move to Child Health Laws—Commission on Legislation to make report. They will be here tomorrow and we will defer this until tomorrow. We have an important item from the Executive Committee referred to the Council that should be discussed tonight when we are more or less in executive session. Dr. Larson, who serves as chairman of the Executive Committee today in the absence of Dr. Everly, would you report for the Executive Committee?

Matters Referred by Executive Committee

DR. LARSON: There are several points that are very important. The first one is legal counsel for the ISMA. The Executive Committee recommends to the Council that effective October 1, 1968, the firm of Stewart, Irwin, Gilliam, Fuller and Myer of Indianapolis be retained to represent our interests. This is a firm consisting of some 20 attorneys in Indianapolis, which is highly departmentalized with experts in many fields—legislation, corporate law, taxation, trial work and these are just a few. The corporation is well balanced; there are eight senior partners. The members of the corporation are divided about equally between Republicans and Democrats. The legislative expert is Mr. Guthrie, who is formerly Speaker of the House of the State Legislature.

DR. STEEN: The Executive Committee instructed Mr. Waggener to look about for appropriate, possibly new legal counsel. Certain guidelines were set down indicating the necessity for a firm bigger than a two or three man firm, because these men can dissipate themselves very quickly, and leave you high and dry, such as has happened with us over the course of years. He came up with some recommendations and this firm was chosen by the Executive Committee to be interviewed. Two of the members of the firm who will work most closely with the association were interviewed this afternoon by the members of the Executive Committee—Mr. Stewart, one of the senior partners and a Mr. Fairchild, who is one of the younger members of the firm, and not one of the partners.

Discussed by Drs. Donato and Steen.

DR. BOWEN: I move that the action of the Executive Committee concerning the legal counsel for the association be accepted.

DR. HILLIS: I second the motion.

DR. STEEN: Seconded by Dr. Hillis. Is there further discussion of the motion? Those in favor of the motion signify by the usual sign. Opposed? Let the record show that there is one "nay." Let the record show that the nay was from the councilor from the Seventh District, Dr. Albert M. Donato.

Dr. Larson then continued that the Council was aware, and approved the action of the Executive Committee in requesting $50,000.00 from the Indiana Blue Shield in assisting in carrying out the Comprehensive Health Plan. The Executive Committee felt that the Council should hear the answer to a letter from the association to the Blue Shield Board of Directors. Dr. Larson then read the letter as follows:

July 25, 1968

G. O. Larson, M.D., President
Indiana State Medical Association
3935 North Meridian Street
Indianapolis, Indiana

"Dear Dr. Larson:

"Your letter of April 26, 1968, and the request contained therein for financial assistance was, as you know, reviewed by the Blue Shield board of directors on Sunday, July 21, 1968. The executive committee first reviewed the request and made the following recommendation to the board of directors.

"During the course of the April board meeting the Indiana State Medical Association officers requested that Indiana Blue Shield appropriate $50,000 to the Indiana State Medical Association so that they might obtain additional field staff so as to further promote the doctors' participation in 'Comprehensive Health Services Planning.'

"It was pointed out in their communication that Indiana Blue Cross had allocated up to $50,000 to help finance a similar activity by the Indiana Hospital Association.

"We have contacted the National Association of Blue Shield Plans to determine if any similar activity is occurring in other Plans in the country. We have been advised that 16 Blue Shield Plans are financially participating in Comprehensive Health Services Plans to a varying degree. Some Plans are contributing directly to the actual Planning Councils. Others are contributing in financial assistance through feasibility studies, etc. At least one other Blue Shield Plan is contributing to their State Medical Association as a result of a request similar to that received here in Indiana. Of the 56 Blue Shield Plans queried, 16 indicated direct financial assistance is currently being offered. Most of the rest indicated that they were either seriously considering a request or seriously considering sponsorship of some sort in this activity. All plans indicated a direct interest and an acknowledgement that such activity can be directly beneficial to the Blue Shield membership.

"Blue Shield of Indiana has a tremendous stake in the growth and the pattern of growth of health care facilities in Indiana. Our present programs cover such things as in-hospital medical care, diagnostic x-ray and lab, radiation therapy, and numerous other services that will be directly involved in comprehensive services planning. Since the review conducted by the National Association of Blue Shield Plans indicated that the highest contribution by a Blue Shield Plan toward this effort was $25,000 and since Blue Cross of Indiana has already offered assistance in the amount of $50,000 toward this same effort, we would recommend that Indiana Blue Shield commit up to $25,000 per year each year for the next two years to the Indiana State Medical Association for the express purpose of obtaining more field staff to encourage the development of comprehensive health planning. As you know, the action of the Board of Directors was to reject the recommendation of the Executive Committee.

"My own personal feelings and observations from the comments made at the Board meeting are to the effect that the Board did not feel Blue Shield had the right to commit its members' monies to the Indiana State Medical Association. I had the strong impression, however, that they did recognize Blue Shield's definite interest and stake in the course of comprehensive health planning in our state.

"You will recall I suggested a possible solution to the dilemma might be the hiring of additional field staff by Indiana Blue Shield and a joint effort between Blue Shield personnel and personnel of the Indiana State Medical Association in promoting physicians' participation in planning committees. Even though there was no specific reaction at the Board meeting, I did receive several favorable comments about the suggestion following the meeting. I have discussed this particular idea with Mr. Waggener, and I am sure you will be interested in his thoughts on the subject.

"Please rest assured that Indiana Blue Shield is anxious to cooperate with the Indiana State Medical Association on this particular project or in every other matter whenever possible.

Sincerely,

Mutual Medical Insurance, Inc.
Richard C. Kilborn (Signed)
President"

Discussed by Drs. Harshman, Taylor, Dukes and Kerr.

DR. STEEN: Is there further comment? Dr. Dukes moves to table. This takes precedence over all other motions; seconded by Dr. McIntosh. I heard only one opposing vote—motion to table is carried.

DR. LARSON: The term of service of the AMA Councils and Committees is for one calendar year, with a maximum of ten consecutive years. We have a list of the vacancies which need to be filled on December 31, 1968. A list of these will be supplied to you by staff and we would like to have your suggestions for filling these vacancies in order that they might be forwarded to the AMA.

DR. STEEN: This is something that cannot be accomplished adequately by a group effort. I would ask that you look these over and give any suggestions that you might have to us at the conclusion of the meeting tomorrow.

DR. LARSON: Other matters referred by the Executive Committee: (1) Continuation of the measles program. I shall read an excerpt from the Executive Committee meeting of June 8, 1968: "Letter from Doctor T. O. Middleton, Chairman of the Commission on Public Health, urging the ISMA's cooperation and approval for the continuation of the measles program." On motion of Dr. Steen and seconded by Dr. Scamahorn, the continuation of this measles program was temporarily approved, pending the action of the Council of the association at their meeting today. We feel that the Council had taken formal action as to whether or not they would approve continuation of this program for another year. Upon motion of Dr. Donato and seconded by many, the continuation of the measles program for another year was approved.

The Executive Committee, at its meeting on June 8, had before it a report of the Commission on Medical Education and Licensure, recommending the ISMA give its approval to Ivy Tech. On motion of Dr. Steen and taken by consent, action on this matter was referred to the Council.

DR. DUKES: There has been a lot of approval for Ivy Tech and many good men are in favor of it. It seems perfectly sound to me and these men are doing a good job. I would like to recommend that we approve it.

DR. STEEN: It has been recommended by Dr. Dukes that we approve the recommendation of the commission. Dr. Taylor seconded the motion.

DR. BOWEN: I would just like to give a little more information about Ivy Tech. It was started by the Legislature two years ago and its purpose is to help train the

school dropout or the high school graduate who does not desire, or cannot afford to, go on to college or who is not college material and the adult who has been displaced by automation. It pays special attention to those who are not college material, or in other words, in the lower 60% of the class. I think this is a very important program and I would like to see it approved.

DR. STEEN: Those who favor the motion to support the recommendation of the Commission on Medical Education and Licensure to approve and support Ivy Tech, signify by saying "aye"—opposed—same sign—motion carried unanimously.

DR. LARSON: The Executive Committee carries an excerpt of my report made to the Council at the meeting on March 8, and I quote: There are a few other recommendations I want to make at this time. The first one is that at the next Council meeting, a comprehensive, up-to-date report from all commissions and committees should be given. I recommend that these commission reports, with maybe a few specific exceptions, be given to the Council at every other Council meeting and that the commission and committee chairmen should have adequate notice so as to have an opportunity to prepare these reports.

DR. STEEN: As you may or may not know it is the responsibility of the chairman to help prepare and approve the agenda of these meetings. The subject matter we were to cover tonight and tomorrow was so voluminous that I asked Mr. Waggener to omit the various reports of these commissions and committees. I would hope that the Council would support Dr. Larson's recommendation and that this becomes effective with the meeting in October, preceding the state medical association meeting and thereafter. Is there a motion to support the recommendation of the president that has been referred by the Executive Committee? On motion of Dr. Kerr and seconded by Dr. McIntosh, the motion was carried unanimously.

DR. LARSON: The Executive Committee had a recommendation from Dr. Corcoran that we should discuss areas dealing with mental health, student health services and future problems with respect to the fees of physicians. This matter was referred to the Council.

DR. STEEN: In keeping with this, you will notice on your agenda that the commissioner for mental health has been invited to the meeting tomorrow to report to you and will be subjected to questioning by this Council. I think it appropriate that the Council approve this recommendation for future meetings, hoping that we can meet with the commissioner of mental health regularly and that he can attend Council meetings in the future. Upon motion of Dr. Donato and seconded by Dr. Reid, the recommendation was approved.

DR. LARSON: The Executive Committee recommends to the Council that the fee for the Councilors' Dinner to be held in Fort Wayne on Monday evening, October 14, be pegged at $10 per head. Upon motion of Dr. Clark and seconded by Dr. McIntosh, the charge of $10 per person was approved.

DR. STEEN: Dr. Clark, will you please come to the front and make an announcement which I know will be signal. (Following this announcement, the Chair will declare the meeting recessed until Sunday Morning at 9.)

DR. CLARK: Mrs. Clark and I would like to have the Council and their guests to be our guests at our home for cocktails before dinner on Monday evening, October 14.

DR. STEEN: Thank you, Dr. Clark—I will ask that Mr. Waggener work with you on the technical arrangements. The Council, with enthusiasm, voted unanimously to accept Dr. Clark's invitation and expressed their thanks to Dr. and Mrs. Clark for their graciousness.

There being no further business, the meeting was recessed to meet at 9:00 A.M. on Sunday. ◀

THE COUNCIL

August 18, 1968

The Council convened promptly at 9:00 A.M., Sunday, August 18 for the continuation of its meeting. The Council was called to order by its chairman, Dr. Lowell Steen:

Roll call recorded as follows:

1st Distr.—Gilbert M. Wilhelmus—present; Eugene W. Austin—absent

2nd Distr.—Joe Dukes—present; Betty Dukes—absent

3rd Distr.—Donald M. Kerr—present; E. L. Wallace—absent

4th Distr.—Robert M. Reid—present; Jack E. Shields—present

5th Distr.—Wilbert McIntosh—present; C. M. Schauwecker—absent

6th Distr.—Stephen D. Smith—present; Frank H. Green—present

7th Distr.—Albert M. Donato—present; John O. Butler—absent

8th Distr.—Donald R. Taylor—present; Paul W. Sparks—absent

9th Distr.—Peter R. Petrich—absent; Clarence G. Kern—present

10th Distr.—Lowell H. Steen—present; Herman Wing—absent

11th Distr.—Lowell J. Hillis—present; James A. Harshman—present

12th Distr.—William R. Clark—present; Frederic L. Schoen—present

13th Distr.—Otis R. Bowen—present; G. Beach Gattman—present

Officers:

G. O. Larson—present
Patrick J. V. Corcoran—present
Lester H. Hoyt—absent
M. O. Scamahorn—present
Frank B. Ramsey—absent

Executive Committee:

Ralph V. Everly—present
Burton E. Kintner—absent

AMA Delegates and Alternate Delegates:

Harold C. Ochsner—present
Eugene F. Senseny—absent
Frank H. Green—present
Guy A. Owsley—present
Jack E. Shields—present
Don E. Wood—present
Robert M. Brown—absent
Kenneth O. Neumann—absent
Maurice E. Glock—present
Dwight W. Schuster—present

Guests:

Glenn W. Irwin—absent
Andrew C. Offutt—present
Lester D. Bibler—present
Dennis Megenhardt—absent
Glen Ryan—present
Charles Aust—absent
William Sheeley—present
Myron Nourse—absent
Sprague Gardiner—absent
L. G. Montgomery—absent
Mr. Donald Dian—present
Mr. David Teegarden—present
George Young—present
Ralph Hamill, Attorney—present

Staff:

Robert Amick—present
Howard Grindstaff—present
Kenneth Bush—present
James A. Waggener—present

Dr. Steen introduced to the Council Mr. Donald Dian, of the Indiana University School of Medicine, vice president of the Indiana Chapter of the Student AMA and Mr. David Teegarden, program director of the Indiana chapter. The Council extended to them their cordial welcome.

Dr. Steen called attention to page 3 of the AMPAC publication called, "Telescope" in which he pointed out that Indi-

ana's contributions ranked first in two classifications out of three and felt that Indiana can be very proud of this.

Delegates to AMA

Dr. Steen then called on Dr. Frank Green for a report on the AMA meeting in San Francisco.

Dr. Green said that he felt the Council was well aware that the delegation did not accomplish all they went to California to do and that they were led astray in part by a sense of feeling of security that Dr. Lester Bibler would be re-elected to the board of trustees. He said, "We found that many promises made to us were apparently not carried out and I think there is something that we can learn from our last two experiences in trying to elect men from our state to high office in the AMA." Dr. Green then reviewed other matters concerned with the election.

DR. STEEN: Let's take the simplest item first—the Implied Consent Resolution.

DR. KERR: I believe our legal counsel should be requested to review this material so as to encourage any legislative change that may be necessary to protect the physician from assault or invasion of privacy or whatever might be involved in drawing the blood even though there is an Implied Consent Law on the books. If the policeman says "We want blood from him" are we automatically protected if we take that under this law?

JUDGE HAMILL: I think it is always best to get as much insurance as you can have, even though you may have sufficient coverage; it doesn't do any harm. I haven't seen this proposed legislation and I would not want to give you a final statement until I had an opportunity to look it over.

DR. REID: I would like to ask legal counsel if it would be possible to start with a simpler application, such as licensed drivers being asked to sign a permit at that time to allow this.

Discussed by Drs. Corcoran, Bowen and Kerr.

DR. STEEN: Is there further comment?

DR. KERR: I move we proceed along appropriate lines with this suggested resolution. Seconded by Dr. Reid and Dr. Smith.

DR. STEEN: We now come to the Resolution on Relations with Osteopathy. I might give you some further background material. Some of you know there have been some community hospitals throughout the state that have been ordered by law to admit to their staff osteopathic physicians.

DR. KERR: Does the resolution simply ask that the president be authorized, or ordered to appoint a committee to study it? I see no reason to object to that and I move that the resolution be adopted. Seconded by Dr. Hillis.

DR. HILLIS: In the second whereas, a license to practice medicine, surgery and obstetrics, they are eligible for hospital privileges, and I think that is probably a true statement but I think that statement can be changed because the law does not state eligible for staff privileges—it says they are eligible to use the facilities of the hospital.

DR. WILHELMUS: I am curious as to how many osteopaths practice in the state of Indiana and where are they practicing?

DR. HILLIS: There are 240 osteopaths in the state of Indiana and the majority of them practice south of State Road 40.

DR. STEEN: The president calls to my attention a Report "F" of the board of trustees of the AMA relating to Resolution 32 which was referred to the board of trustees on the Council of Medical Education with the recommendation that it be considered as a part of an overall program aimed at the full amalgamation of osteopathy with medicine.

DR. CORCORAN: Does this go to the House of Delegates for action for implementation if the House adopted it?

DR. STEEN: Yes.

DR. CORCORAN: Since we already have a Commission on Inter-Professional Relations, why can't we refer this to that commission for study?

DR. HILLIS: Now, I have no objection to this resolution because it is simply a further study of it, but I do object to some of the wording in the second paragraph because it implies that they must be taken onto the hospital staff and that is not right.

DR. STEEN: How would you amend the second paragraph?

DR. HILLIS: By striking the words "hospital staff privileges" and inserting "they are to use the facilities of the hospital."

DR. GATTMAN: We have had the same problem. We have admitted about five osteopaths to our staff, which we feel is a better way to handle this situation.

DR. STEEN: The question has been called. A roll call vote was requested.

DR. STEEN: Mr. Secretary, will you call the roll?

Dr. Wilhelmus— nay; Dr. Dukes— nay; Dr. Kerr— aye; Dr. Reid— nay; Dr. McIntosh— nay; Dr. Smith— nay; Dr. Donato — nay; Dr. Taylor— aye; Dr. Kerr— nay; Dr. Steen— aye; Dr. Hillis— nay; Dr. Clark— nay; Dr. Bowen— nay.

DR. STEEN: The motion is defeated.

DR. DONATO: I would like to explain my vote of no. I do think the osteopaths are a recognized group, and as far as Marion County is concerned, we get along with them just fine. I think they are in the process of building their own hospital. As a matter of fact, I think they should be accepted in the state medical association. In order to get on any staff, they would have to meet qualifications and stay at a certain level the same as M.D.'s to remain on our staffs. This is entirely personal and I do not know that I can say this feeling is shared by other members in the Marion County Medical Society but I strongly feel that it is time we do something about these men. I think we should take them in. I think they would be willing to abide by our rules.

DR. REID: I would like to add to that — I voted against it primarily as a method of procedure. I think this should be referred to the proper commission and a report designated — a specific report from them. I would, therefore, move that this be referred to the Commission on Inter-Professional Relations. Motion seconded by many.

DR. STEEN: It has been moved by Dr. Reid and seconded by many that Dr. Larson's proposed resolution be referred to the Commission on Inter-Professional Relations for study. Motion was put to vote and carried.

DR. STEEN: Now we come to the knottiest problem with which we have had to deal for a long time—namely the suggestion of the president that a very sophisticated field staff be inaugurated and that a significant increase in the dues structure be requested. I would indicate to you that this is a very serious problem. I think there is a necessity for upgrading the district medical organization and for further logistical reports from county societies. I think this is something that requires in-depth study.

DR. DUKES: You are going to have a hard time selling $50. I think it can be done eventually but I think they are going to have to be educated.

DR. KERR: I agree with Dr. Dukes and add to it that this is a little matter for Dr. Bowen's Committee to Study Membership Matters. I believe before any such action as suggested by our esteemed and honored president that we might well look to the responses of the questionnaire.

Discussed by Drs. Reid, Taylor, Wilhelmus, Dukes, Clark and Bowen.

DR. BOWEN: I move that we make this a joint effort of the Commission on Constitution and Bylaws and the Commission on Future Planning. Seconded by Dr. Hillis.

The question was called and the vote was in favor of referring this matter,

jointly, to the Commission on Constitution and Bylaws and the Commission on Future Planning.

DR. DUKES: I think we might have a pilot program set up for these commissions to work with to determine the feasibility and the reception it would get. I so move.

DR. STEEN: Dr. Dukes moves that a pilot program be set up so that these two commissions can work with such a program to gain fuller understanding of the program. Seconded by Dr. McIntosh. Discussed by Drs. Wilhelmus, Dukes, Taylor, McIntosh, Hillis, Donato, Larson and Kerr.

DR. STEEN: If there is no further discussion, I call for a vote on the motion to establish a pilot program with which these commissions can work. A show of hands —the motion was lost.

DR. STEEN: This concludes the action on the report of the president.

DR. KERR: I would like to make another recommendation that this matter be referred to these two commissions mentioned but not that they be directed to have a pilot study.

DR. STEEN: You refer to the matter of if they wish or do not wish to have a pilot study?

DR. KERR: Yes, that the intent be directed to them so that they will have the information upon which they can properly work.

DR. STEEN: Is there a second to Dr. Kerr's motion? Seconded by Dr. Dukes, put to vote and carried.

DR. DUKES: Just a clarification— then if the commissions want a pilot study, they can have it? Yes (everyone in unison).

DR. STEEN: Yes, but they are not so mandated. So that we do not waste the time of the individuals who do not need to be here for the entire day, we will now move on to the reports of guests so that these individuals who wish to leave, may do so.

Reports of Guests

I would like at this time to again introduce to you Mr. Donald Dian and Mr. David Teegarden, of the Indiana Chapter of the Student AMA. Would you gentlemen please stand? We will call upon the program director, Mr. Teegarden, at this time if he would like to make some comments.

MR. TEEGARDEN: First, let me say, it is a real pleasure to be invited here today to speak to you gentlemen, and I would like also to give my thanks to Mr. Waggener and his staff for giving us this opportunity to attend this meeting and get a somewhat closer exposure to organized medicine. At the present time we are in the process of planning with Mr. Waggener a program whereby we can use the facilities of the ISMA to hold our monthly meetings, and at the present time, we have come to an agreement whereby we can use for September, October and November your facilities here to hold our monthly meeting.

Now, my position with the Student AMA is one of program director, and I will explain to you what I will do. As program director, I will try to direct the programs for each monthly meeting throughout the academic school year at I.U. At the present time, our September meeting will be sponsored by Curtis & French of Indianapolis and we will have a buffet type meal catered by Catering Unlimited of Indianapolis. This is just giving Curtis & French the opportunity of course, of so-called public relations and the opportunity to explain to us a little bit about what they have to offer to medical students in the way of medical supplies.

I hope to have a program on medical ethics. It seems as though our program at I.U. is so compact and so crowded that we do not have too much time to study the patient-doctor relationship, and the students need to know this. This is of primary importance to us. Because you don't learn from textbooks how to talk to patients, and you don't learn this except from men who know and have had experience doing it. We hope to have a meeting on forensic medicine—the doctor and the law— which I can draw from this meeting is very important.

I hope to have a meeting on community health, possibly as a speaker, Mayor Lugar of Indianapolis, to give us a non-medical viewpoint of the community health of Indianapolis, which I think will probably be the best example of this state. Then again, the medical students might be informed of the investments—of what a medical student will do when he becomes an M.D. when he gets out into the business world. Because it seems to me plenty of us may be ignorant of this idea.

And then I would like to have a meeting concerning organized medicine to have a representative of your organization to come and talk to us about organized medicine on the local, county, state and national level. This again is something that is not included in our medical curriculum. It is through things like Mr. Dian and myself being here today that we learn about these things. We would be totally unaware —if we were to come in after our internship or residency and sit in on this meeting—we would be totally blind, so we need to know about these things. And again, maybe we can have some programs that aren't geared to this, such as having a race driver at the time of the Indianapolis 500 come to talk to us, but what I want to stress this morning is that we have to work closely with an organization like yours.

We are what you might say "premies" and we need a lot of help. In the past we have been going two different paths, and we have a new president now with a lot of enthusiasm and a lot of new officers now who are ready to work. And again, let me say thank you for letting me come today, and I hope to be back with you again soon.

DR. STEEN: The dean has been telling me that there is a new breed of "cat" here in these medical students and I believe him. I am delighted with what I hear and see.

MR. DIAN: Thank you. Dave discussed his involvement in the SAMA as program director. I will discuss SAMA as a whole at Indiana since I am the vice president. SAMA has at this time about six projects with which we are involved with the students. Some of them are just small token type programs that are of some benefit to the student, such as, we run a non-day movie once a week—and one which we feel is more significant is our one day preceptorship for freshmen and sophomores. This has been going on for two years and is designed for freshmen and sophomores who enter medical school and do not get close to the practice of medicine until they are juniors. We feel that this program enables them to see medicine in practice and we would like to expand this to a point where we have a statewide directory of physicians who are interested in having students for one day. At the present time this has been limited to a radius of 70 miles of Indianapolis. This serves a two-fold purpose.

First, it gives a chance to a student during his vacation time when he is in his home town or some other town to visit with a physician. Another anticipated benefit of this statewide directory is when a student reaches his senior year and is interested in practicing in some city in the state of Indiana, he will have a list of physicians to which he can call or write and discuss the possibilities of setting up a practice in that city.

Another one which I think is extremely significant, and standing here today I do not know how you will react to this, but we have formed a Committee for Community Health in Indianapolis. In the last four weeks we have conducted meetings with the community leaders on the south side of Indianapolis and we are presently negotiating with them for space for a free

clinic for indigent people. We plan to staff this with members of I. U. medical students, under the supervision of a physician who will be willing to donate his time. We have just discussed this with selected faculty members of the medical school and they consider this a worthwhile project.

(The report was discussed by Drs. Taylor, Owsley and Ochsner.)

Dr. Steen asked whether or not the students had made contact with the Health and Hospital Corporation or the Marion County Medical Society. He said that the Liaison Committee with the I. U. School of Medicine had recently met with Dr. Lukemeyer and Dean Irwin and had discussed this proposed program and assured the liaison committee that contact would be made with the Marion County Medical Society.

DR. STEEN: Thank you, gentlemen. Let us proceed with the report of the State Commissioner of Health, Dr. A. C. Offutt.

DR. OFFUTT: I have two items—one is information and the other is in behalf of Dr. Young. Some years ago the Council approved a program of organized care for the sick and disabled which we published in the *Bulletin of the State Board of Health*. It became a controversial document not because of the content, but because of the sponsorship. Because of the changes in the situation and with regard to Medicare, it was felt by the Commission for the Aged that we should bring it up to date. We have done so. Mr. Chairman, I would ask the Council's approval of the distribution of this new document.

DR. STEEN: You have all been mailed a copy of this. What is your desire?

DR. TAYLOR: On page 1, the last paragraph, I don't agree with the wording—it says Blue Cross, Medicare, and other health insurances have begun to respond to the need of home care by providing for this in their standard contract. As far as I know no one has a contract with Medicare. Secondly, Medicare is not health insurance, and I think this could be worded in a better way. Furthermore, I think where Blue Cross is mentioned it should be hyphenated Blue Cross-Blue Shield—not Blue Cross.

DR. STEEN: Will you make a note of this— where these two words are mentioned—it should be hyphenated—Blue Cross-Blue Shield. What is your pleasure, gentlemen?

DR. KERR: I move it be distributed. Seconded by Dr. Donato, put to vote and distribution was approved with recommended changes.

DR. OFFUTT: I would like to respond to Dr. Taylor's comments. I think they were very well taken.

DR. OFFUTT: The second item is I am pleased to tell you that we have employed as of the first of September and there will be in our office an office on Comprehensive Health Planning which will plan the guidelines for the operation of this program which requires that there shall be a full-time staff. After the first of September, we will be able to move in some help with organized medicine in getting the plans done. The gentleman who has taken this job is a man I have known for some thirty years; a man whom I worked for in the Army and who has been working in Indiana. He left Indiana and has returned to work for us. His name is Dr. Dean Chandler—who was at one time health officer in the city of Hammond. He is very well qualified because he is highly skilled in planning and logistics. He did, as some of you may recall, head the disaster planning program for the AMA when he retired from the Army.

I would also like to mention, although I will not dwell on it because of the time element, but after about five years, we have reorganized the State Board of Health. We have tried to modernize the operation on the basis that with each succeeding legislative operation, we have gotten more and more things to do and each time we have had to carve out a place in the organization for them. Actually, what I have done is to head up three commissionerships—one is for administration, and I think most of you are well known to him—and that is Robert Yoho—who will head this division. I have asked for an assistant commissioner for medical operations, and this will be headed by Dr. Spolyar and the third is the commissioner for environmental health—Blucher Poole.

I have further broken down the Board of Health into three basic functional areas, each with two bureaus. Under the assistant commissioner for administration is a Bureau of Administrative Development and a Bureau of Management and Services. The Bureau of Administrative Development has a program division of grants and planning. This is necessitated by the new Comprehensive Health Program and this is where Dr. Chandler will eventually go. Under Dr. Spolyar will be the laboratories with no change, but there is an enlarged Bureau of Medical Services. From the eight bureaus, we have gone to six, and under the Bureau of Medical Services is where you will find the traditional communicable disease, mental health, health facilities and hospital and institutional services, etc. I hope in the future to be able to combine these two divisions into a single division if I can find a doctor qualified to run it.

Also in this bureau is where we find the Division of Medical Care and Administration which is better known as Medicare. In the last one we have the Bureau of Food and Drugs. This is new but has been in the division but because of the upsurge of interest in meat inspection and dairy products and all these things, we felt that it was necessary to set this up at bureau level. The Bureau of Engineering includes air pollution, water pollution, radiological health, industrial hygiene, and sanitary engineering so while it may seem we have vitally changed, we actually haven't. We have only given visibility to some programs that have become more important financially and personnel wise.

The last thing I would like to mention to you is that we will have a financially significant legislative program and I will meet with the Commission on Legislation to discuss this, as we will need the support of the medical profession for some of the new developments in legislation on water pollution and air pollution specifically. As far as the meat inspection program is concerned, I don't know what to tell you, because at the moment, in order to comply with the federal act, we will have to change the present Indiana law. There are two federal laws having significant financial differences. To comply with the federal program will mean a difference of one million dollars with a staff of 116 or more people. Under the Talmadge-Aiken Act, the Federal Government will participate in 50% of the cost—under the act known as the Wholesome Act, the Federal Government will participate up to 50%. I will discuss this in detail with your Legislative Commission. Mr. Chairman, I thank you very much.

DR. STEEN: Thank you, Mr. Commissioner.

DR. STEEN: Now, we are pleased to have with us today for the first time, the Commissioner of Mental Health for the state of Indiana, Dr. William F. Sheeley.

DR. SHEELEY: I am happy for this opportunity to meet with the Council, because we in the Department of Mental Health are going to be increasingly dependent on the family physician, private practitioner, as we try to implement the programs we have in mind. Perhaps by way of background, I should say we are making certain assumptions in the department which guide our policies and our practices.

One of the assumptions is the progress of the last 50 years—mostly over the last 10 or 20 years—in psychiatry has made it possible for one to think in terms of rapid treatment of people who are mentally ill. The progress, too, in thinking of mentally retarded persons and what can feasibly be seen as a goal in this management has lead

as to another assumption. That assumption is that many people who are mentally retarded, and particularly those in whom intellectual impairment is relatively mild, that many of these people can and should function in their proper communities both socially and economically. And, therefore, our program should be so geared, as to assure the maximum restoration of such individuals to social and economic function —and when I say economic, I mean get jobs with pay-participation.

As you know, and I'm sure every physician around this table has been using psychiatrophic drugs in a certain amount over the recent years, they have certainly revolutionized the treatment of psychiatric conditions and they have also revolutionized our thinking as to how the patient who has psychiatric conditions should be met. We think it is no longer defensible to see lifetime institutionalization as often the management of choice. We believe institutions should provide relatively brief services in an intensive nature and such services should be oriented to as early return as possible to the community and to the fullest participation by the patient in the community.

In psychiatry, gentlemen, we have made the error of excessively overprotecting, excessively institutionalizing our patients, and as I said the psychiatrist is supposed to understand about the influence the setting has on the individual—on his morale, on his invalidism, and it took us a little while to hear the message our colleagues in surgery related to us, but we now understand that. According to them, we are examining very critically both the patients who are presently in our hospitals and patients who are coming to our hospital to see how we can keep to an irreducible minimum the length of time which a patient must actually stay in our hospitals. We have many individuals in our hospitals now which you wouldn't believe. They are actually invalids by accepting hospitalization. We recognize our errors and will do everything we can do to correct them.

I'm sure you are all aware of the program for several years now which has stimulated, fostered, and supported and encouraged the development of facilities in the community and I am referring now to mental health clinic facilities for mentally retarded and more recently the comprehensive mental health center which not only provided outpatient services but in the general hospitals, inpatient service, consultation with practicing physicians as well as other significant peoples, and public education, as well as emergency services. The department is continuing its efforts to expand these services to support them.

The department is also trying to respect the principle of continuity of care which holds that an individual patient in the life history of his illness has a changing requirement in terms of the treatment that he needs. Sometimes he needs 24 hours a day, seven days a week hospitalization—other times he needs little more than a physician who will see him at periodic intervals of more than two to three months perhaps to regulate his psychiatrophic drug dosage. Perhaps to keep track of him, the things that are going on.

We then are making every effort to combine the programs which prevail in the hospital of the department and the programs which prevail in the community and to combine them, to fuse them, to make them truly a continuous system of care, whereby a patient with facility can move from one element of the system to another as to his changing needs of care. The hospitals at the present time are reaching out to the practicing physician. Each hospital is trying to work out with the county societies the kind of collaboration to insure the best kinds of relations with hospitals and practicing physicians. The hospitals are becoming involved with continuing education programs, which we see primarily as an ice breaker—the treatment of the hospital, on one hand, the practicing physician on the other.

We hope that these programs will serve at the meeting point between the staffs of the hospitals and the practicing physician, and that between them, they can work out solutions to some of the problems between them. They can work out ways to each support the other, in which each, therefore, can provide a better system of care. There are many other details I could bring to you; however, perhaps it would be more appropriate if I made myself available for questions.

DR. KERR: One thing we have tried to get for many years is a brief, but concise and immediate report to us on the patient who is released because I think, universally, we don't know what happened or when until we find out either he has become ill or the police have been called.

DR. SHEELEY: As a superintendent of a mental health hospital and now as commissioner of mental health, I couldn't be more sympathetic with your request. If you do have specific problems, I would be glad to hear from you.

DR. CORCORAN: Could you very briefly tell us what institution under the Department of Mental Health handles the relationship of the institution with the commissioner—are these autonomous in their areas, and I gather there is more than one type of hospital you have.

DR. SHEELEY: In brief, there are two kinds of hospitals. (1) Those primarily concerned with mental retardation and (2) those primarily concerned with the treatmen of mental illness. In addition, there are two or three special hospitals—such as Northern Indiana Children's Hospital in South Bend, the Fort Wayne State Hospital in Fort Wayne, and the Muscatatuck State Hospital, and these three are primarily dedicated to mental retardation. Hospitals primarily dedicated to psychiatric health include hospitals at Westville, the Norman Beatty Hospital—the hospital at Logansport, and the hospital at Richmond, Indiana —Central State Hospital in Indianapolis, and the Madison State Hospital.

At Evansville, there is the Evansville Psychiatric Children's Center, which is addressed primarily to children up to 13 years of age. Also, in New Castle the State Hospital was originally founded as a Colony for the Epileptic—it does now have some psychiatric patients but it is still primarily a hospital for patients with seizures which are difficult to control. The relationship to the department is that each of these is a component institution within the department with the superintendent being accountable to the commissioner. The commissioner in turn is responsible for the programs which are conducted.

DR. STEEN: Again we want to thank you, Dr. Sheeley for being with us. We will move on.

Dr. Megenhardt is not here. Is there someone to report for Blue Cross? No report. Dr. Ryan, chairman of the board of Mutual Medical Insurance— Blue Shield, will make his report.

DR. RYAN: Thank you, Dr. Steen. You have already been informed of the action of the board regarding the request for the financial assistance in Comprehensive Health Planning so I will not report further on that. I would like to report to you that in our group contracts that over 50% of the group now have the usual and customary concepts and I want to emphasize that this is in the group contract. Cooperation of county medical societies has been very good and I notice that more physicians are discussing fees prior to their services which helps Blue Shield considerably.

As far as the Motors are concerned, negotiations with the Motors has resulted in an indemnity for well baby care, consultation and the number of hospital days changed from 365 to an unlimited number. The care of pulmonary tuberculosis has been increased from 30 to 45 days of hos-

pitalization and there has been an increase in the consultation benefits; in other words, there will be no limit for consultations per admission, and as I have previously reported to this Council, the drug program is effective in October, 1969.

We have hired an additional man in the professional relations department, and our annual workshop with the medical assistants will start again in September. An action taken by the board, in which I am sure you will be interested, was one authorizing the company to pay the doctor directly, rather than making out the checks to the patient and the doctor. This was brought on for several reasons—one is that we have had a great number of forgeries, and as you know Blue Shield has always given the payment to the doctor, and we feel this way it will be quite an asset to the patient and the company too. The last comment—one in sorrow— is to tell you that in June of this year, Blue Shield lost $67,148.00, but we don't expect that trend to continue.

DR. DUKES: When does the direct payment begin?

DR. RYAN: We are originally shooting to begin in November, but it looks now as though it will be the first of January, 1969.

DR. TAYLOR: There is a problem recently that has been brought to my attention both personally and by other physicians on this Medicare-welfare program. I think a year ago in June we voted that there may be a six months cut-off at the time when Medicare-welfare payments would not be honored. I think it is proving in practice as impossible sometimes to get these things in because physicians many times don't know that a given patient is covered by welfare under this program. Physicians are losing payments because six months doesn't allow time to do the work. Reflecting on this, I am wondering if this can be changed.

DR. RYAN: I don't think I can answer your question, but will be glad to check with the administration for an answer.

DR. DUKES: I remember they asked whether we wanted six months or a year and we voted six months. At that time, I don't think we realized it would take that long and I think we could recommend it be a year and it would be satisfactory.

DR. STEEN: I would like to refer this matter to the Council Liaison Committee with Blue Shield and request that they discuss this and report back to the next meeting of the Council.

Now, under Report of the Commission on Legislation—Dr. Schuster.

DR. SCHUSTER: Mr. Chairman, with regards to the item on your agenda—particularly, the Child Health Act of 1968, I report that this is still in committee in Congress, and it seems unlikely anything is going to develop during the present session. I thought perhaps you were interested in Title 19. I don't want to take the time on the many items on the legislative agenda but I thought perhaps you were interested in the Title 19 situation.

I don't know whether you have the bill or the law that was passed and vetoed last session or not, well briefly stated, the Legislative Advisory Committee has recommended that the same bill which did pass both houses in 1967 be resubmitted this year. In order to have the income eligibility the same as it was last time, as you may recall it was $1,800 for a single individual, $2,400 for a couple and $600 for each additional dependent. In order for them to have this same income eligibility which the Legislative Advisory Committee recommends, and which the welfare department recommends, it will be necessary that the Legislature change the age of the dependent children limits, because of Federal legislation limiting the amount of Title 19 funds to 133% of the ADC limits. So there will be, I'm sure, legislation suggested and it has been proposed to raise the ADC limits to $150 a month for the mother and the first child and $35 for each additional child. In this way, then the proposed income limits per Title 19 would be possible.

As far as the rest of the bill is stated it is the same, I think that we had gone over that before, it has been satisfactory from the standpoint of our interests—the usual and customary fees, the general mechanism of the bill. I won't go into that unless you have questions. I have met with Mr. Kelley and you may be interested in the projected costs of Title 19, with the proposed income limits $1,800 for the first person and $600 for each additional person. At the present time the cost of medical care from public funds totals $35,900,000—eight million dollars from the Federal government, $15,450,000 from the state and $12,450,000 from local tax units. Under this new proposal of utilizing Title 19, the total cost would be $44,600,000—roughly nine million dollars more of which the Federal Government would pay $18,900,000 and the state would pay $25,700,000. You will notice that there is no provision there on local funds and this is because the state would take over all these and so they say under this situation the Federal funds were increased by almost 11 million dollars, state funds increased by 10 million dollars and local tax funds were decreased by 12½ million dollars.

I think the thing the Legislature will be concerned about are the facts that some of the proposed or projected costs cannot be pinned down and this comes in this group of patients who are now welfare patients but who have in time become medically indigent—it's a fluctuating thing and it depends on the state of their income so that although they project the possibility of about two million dollars (that figure can of course be considerably more and I don't think there is any way anyone can say exactly what that figure will be). I thought those figures might be of some interest to you and if there are questions relative to Title 19 legislation, I will be glad to answer them.

DR. TAYLOR: Is there anything in there on the mechanism of payments to physicians?

DR. SCHUSTER: The mechanism of payments to physicians is the same as it has been—namely the submission of claims through the welfare department. There is a feature that they may utilize outside contractors to do the work similar to what Blue Shield is now doing under the Medicare program.

DR. BOWEN: I have detected a very definite feeling that there is going to be considerable resistance to the implementation of this law. Have you uncovered any such resistance, and what would the feeling of the Council be? I feel if we do not enact this law by 1970, the Federal Government will withhold all of the welfare funds to the state and the best figures I can obtain is that the state would lose approximately 70 to 75 million dollars over a two year period and the state of Indiana would have to institute its own welfare payments and program for the aged.

DR. SCHUSTER: I personally haven't heard anything recently; it was the feeling back in the other session that there may be some attempt to put limitations on it. In discussing this, I find that we will not be able to do this as our present welfare program is so comprehensive and all encompassing that it makes it more difficult because the federal law provides that we cannot provide less provisions under this program than under our existing welfare programs.

DR. GREEN: May I ask two questions? Do you feel first of all that our Council has gone on record as being in favor of Title 19?

DR. STEEN: That is right.

DR. GREEN: Do you feel that it is necessary that this group re-emphasize this fact—that we are all for this?

DR. BOWEN: It would help me considerably to know what your desires are, as I have mixed emotions about the whole program.

DR. STEEN: Dr. Larson has requested

that the information given by Dr. Schuster be sent to all councilors and each councilor should carefully review this material. I would also hope that Dr. Schuster would appear before the Council meeting, in October, preceding the House of Delegates, to give us an opportunity to discuss again what our stand will be and how we will maintain close communication. I think it is very important that the Council and the Legislative Commission work closely on this matter.

DR. STEEN: The Council Liaison Committee with Blue Shield has no report. Dr. Taylor tells us that the Council Liaison Committee with Blue Cross has no report. Dr. Petrich, chairman of the Liaison Committee with Indiana University School of Medicine, is not here. Dr. Hillis, do you have anything further to report on the Council Committee on Emergency Medical Services?

DR. HILLIS: I made a report last night and have no further report at this time.

DR. STEEN: Dr. Donato, do you have anything to say about the Governmental Medical Services Committee?

DR. DONATO: We have no activity report at this time.

Economic and Organization Matters

DR. STEEN: The membership report is contained in your book—are there any questions? If not, we will proceed. Dr. Ramsey says he has no report—other than asking if there are any suggestions relative to the nomination of the Editorial Board.

DR. RAMSEY: As far as I'm concerned the present membership is satisfactory. (At this point, Dr. Kerr assumed the chair in the absence of the chairman).

DR. KERR: You have heard these suggestions, and I believe the procedure is that these nominations shall be presented to the Council meeting to be acted upon by the Council at its October meeting. You have heard the suggestions of Dr. Ramsey and you might want to talk to some of the other councilors between now and the meeting in October.

DR. KERR: Do we have a report from the Commission on Convention Arrangements?

DR. GLOCK: Yes. I am not a member of this committee but Dr. Aust requested me to report and as far as we know we have everything fairly well organized and we would appreciate any help or suggestions from the members of the official family—from the Council. I have just talked with Mr. Waggener and as you know we have this program going on Thursday morning on socio-economics. I would hope that every councilor would inform the members of his district about this—urging them to attend this important session.

As you know, we have the president of the AMA, Dr. Wilbur; the president-elect, Dr. Annis; Dallas Sells, former head of AFL-CIO; Mr. Gardner of the HEW, and others who will speak on the program which should be most informative. It is hopeful that some of these men will take off after us a little bit—somebody who will provide a little bit of controversy. As you know, we cannot always have a program that is laudatory of the doctors 100%. Every doctor in Fort Wayne is going to make it a point to invite at least five influential leaders to be their guests for this session. I certainly hope that we have a good crowd.

DR. KERR: I think this is a very significant thing which we all should remember.

DR. KERR: Dr. Bibler will now give us a report on the Student Loan Committee.

DR. BIBLER: Thank you, Mr. Chairman. The Student Loan Committee met this morning. We only had one application but we were advised he had secured a loan elsewhere so there were no loans to consider at our meeting today. We have submitted a report to the House which is contained in the Handbook, but I would like to report at this time the committee has five doctors under the program who have a total delinquency of $1,648.48. The committee desires that the legal counsel be instructed to contact all of these delinquent accounts to expedite their payments, and a copy of these letters be filed with the committee.

DR. KERR: Shouldn't there be a registered receipt requested?

DR. LARSON: I move the acceptance of the report. Seconded by several. Motion carried.

DR. KERR: Do we have a report from Dr. Dukes' Committee on Business Consultants for *The Journal?*

DR. RAMSEY: Dr. Dukes has informed me he has nothing to report.

DR. SCAMAHORN: I have a treasurer's report.

DR. KERR: Please proceed.

DR. SCAMAHORN: The cash report is actually $53,000; investments—$306,000; giving us a total of $360,000 that is net worth. For our July expenditures we had a net loss of expenses over income in the amount of $3,300; however, for the first seven months of the year we are in the black for a total of $13,700—and, actually, we are running right along with what we thought when we prepared the budget. I do want to inform you that $25,000 has been taken from our funds and invested in Johnson Mutual Fund, Inc. This is a no-load fund and investment has been made primarily for growth. We bought 1,127.14 shares at a net cost of $22.18 per share. As of the present time the shares are worth $23.17.

DR. KERR: Will there be a motion that the treasurer's report be accepted?

DR. TAYLOR: I move it be accepted. Several motions to second.

DR. KERR: The motion is carried.

DR. KERR: Dr. Bowen, do you have a report on the Council Committee to Study Membership Matters?

DR. BOWEN: Mr. Chairman, the House of Delegates in 1967 directed the Council to conduct a membership survey to determine what the thoughts of the individual members were concerning their state association. The results on this survey then would be a guide for our use to improve our services to the local societies and individual members. This Council appointed a subcommittee to study the membership matters and the committee has been functioning. The thought at first was to have a professional survey but the cost was estimated to be about $20,000 or more.

We studied a copy of a comparable survery made in Illinois and decided that the survey made by Illinois would be approximately the same in results as one we might conduct in Indiana. Therefore, our committee has devised a survey form of five or six pages in length and it is our thought that we should provide this survey form to the secretaries of each of the societies and make them responsible for getting them returned to the headquarters office. The results would be tabulated by the state headquarters and the results reported to the Council, and, hopefully, to the Joint Committee on Constitution and Bylaws and the Future Planning Committee to aid them in their deliberations on their work.

(Dr. Steen again assumes the chair.)

DR. STEEN: What is the wish of the Council. Do you wish to inspect the work done by the subcommittee or mail them out? It is by consent of the Council that the survey form be mailed, as outlined by Dr. Bowen.

DR. STEEN: We are now ready for the Council Committee on Economics and Fiscal Matters.

DR. REID: The report is in two parts. The first relates specifically to the matter of remuneration and reimbursement of expenses. I have talked in varying degrees of details with most of the adjoining states, the regional AMA office and some other people in the county relative to some of our practices.

First, relating to expenses—specifically

to the president. A special separate joint checking account will be established by the ISMA. The president may use this account for the payment of all of his expenses directly related to his activities as president of the ISMA. Transportation costs will be paid from this account, either by the president or the ISMA, whichever is more applicable. Telephone credit cards will be coded in order that charges incurred by the president may be paid from this account by the ISMA. Charges related to food, lodging and transportation incurred by the president and his wife in the recognized official organizational functions may be paid from this account.

The president-elect would be exactly the same as the above for the president, with the exception of substituting the term, "president-elect" for the president whenever it occurs. The officers and members of the Executive Committee, other than the president and president-elect, councilors and alternate councilors—all expenses incurred in the activities relating to the official business will be reimbursed by the ISMA, upon receipt of properly itemized accounting of such expense. Delegates and alternate delegates to the AMA—expense incurred in the course of attendance to the two regular annual meetings of the AMA will be offset by a payment of $500 per meeting. A check in this amount will be made available to the delegates upon receipt of their intention to attend. It shall be understood that in the event such delegate is unable to attend a particular meeting, the amount of the check will be returned to the ISMA within 30 days of its receipt.

Secondly, expenses incurred by the delegates in attendance at other meetings of the ISMA, or AMA, having been directed to attend by the appropriate authority of the association, may be reimbursed by the association upon receipt of a properly itemized accounting of such expense. Members of the ISMA commissions—reimbursement of travel expense to regularly held meetings of the particular commission will be made upon receipt of a proper claim specifying the mileage. In an occasional situation where a member or members of the ISMA are directed officially to perform a particular function for the ISMA, he may expect appropriate reimbursement upon receipt of properly itemized accounting of such expense. All expense claims will be subject to review by a committee of the Council designated by the chairman of the Council. Requisitions will be signed by an individual or individuals indicated by this committee. In event of disagreement regarding the validity of a claim, the judgment of this committee will be final.

DR. STEEN: Dr. Reid, I should like to point to one thing that comes to my mind with regards to what your report states. Now, in the past regarding AMA meetings, there are some individuals who serve the AMA and also serve on a council or a committee of the AMA. Now, these people are entitled to reimbursement by the AMA and the manner in which this has traditionally been handled by this organization is that the AMA pays half of it and the ISMA pays half of it. I think some provision ought to be made to continue that system in your report. Another point is that all checks amounting to $100 or more are sent to the chairman of the Council or the treasurer for signature. Only the travel vouchers for members of commissions and committees, amounting to less than $100 are paid out of the Petty Cash Account on checks signed by Mr. Waggener.

DR. REID: To comment on that, I apologize first on your first point—that item was just an omission. I have not had a chance to discuss this with the members of the committee but probably in those cases where there is a certain percent reimbursed by the AMA, we would reduce that payment to $250 per meeting rather than $500.

DR. CORCORAN: May I inquire—did I understand you to tell me that your proposal is for these to take effect after the currently elected officers go out of office?

DR. REID: I think the comment I made to you on that related to the remuneration for time lost rather than expenses. We hadn't attempted to set any certain time. I don't think we should make any specific change if someone is committed with an understanding.

DR. STEEN: In other words, what you are now talking about is the per diem?

DR. REID: Yes. This has nothing whatsoever to do with reimbursement for professional time lost. These are strictly direct expenses incurred in the routine of carrying out duties of the ISMA as an officer.

DR. STEEN: I think this is good.

DR. REID: I don't necessarily think the action is necessary right now—it was my thought if you were in agreement, I would have a copy of this material and submit it to you and possibly reconsider it at the October meeting.

DR. STEEN: That is excellent. Is there further comment? If not, we will discuss it further at the October meeting. I think the committee should be commended on the excellence of the work which they have done. Dr. Clark, do you have a report on the Council Committee on the Orientation of New Members?

DR. CLARK: The plans for the Orientation of New Members includes their being contacted by personal letters from the president—and the field men are attempting to make as many personal contacts as possible. I certainly hope this goes well and a lot of it is going to depend on you, as councilor, to try to contact these men to help accomplish this task.

DR. STEEN: Does anyone have a question to propose to Dr. Clark? If there is none, thank you, Dr. Clark—you have made a heroic effort and you are to be commended for the work which you have done.

DR. STEEN: We will now backtrack and have the report of the president-elect, Dr. Patrick J. V. Corcoran.

DR. CORCORAN: Mr. Chairman, Mr. President, I'm sure you will appreciate my being as compendious as possible—and I will—as much as possible. There are a few items I have to take up—I think today, one is—and I'll take them somewhat in order of action—I'm faced with the appointment of commissions and committee members for the coming year. I've asked Mr. Waggener to mail to each of you the current membership rolls of each of the commissions and committees and I do ask that you promptly submit any recommendations that you may have or any vacancies that may be available.

I talked to Jim and I think this is an opportune time to reappraise the assignment topics for the commissions, and he does have a table of operations which I think he is going to bring up to date; we are going to look it over. There are several items—as an example—I think Junior Day should not be under Public Health but should be under Medical Education and Licensure. I think there is some reshuffling we should face up to and appointment of new members is important. I not only think members of the Council should name prospects from their district but also openings for members-at-large. I think Jim and his staff will have some good suggestions which they can make.

In July, I wrote to each of the chairmen of the commissions and asked them for suggestions as to how we can help them, things they should like to do, things that were unfinished, to appraise the functioning and the interests of their commission and to make suggestions for reappointments or new appointments. As of now, approximately one half of the chairmen have replied, and they have given very good, candid and comprehensive summaries which I find very heartening. The attendance record I have been provided for a number of meetings is in some cases rather

deplorable, and I would like to counsel with the Council as to whether you would authorize to the president, as the Bylaws provide, to replace men whose terms are just not yet complete who have never attended a meeting—or who are not interested.

My inclination would be to authorize me to contact these men and query them in a rather positive manner as to how they would like to proceed in the future and if they would be willing for us to put someone in from that district who would be willing to participate. Under the Bylaws the Council has the authority to replace members whose terms are incomplete. And likewise, I think this group is better able to submit ideas and items for the agenda of the commissions and in fact, I beg of you to put into the hopper between now and October any projects you think we should initiate or which we should pursue and let us then provide the commissions with these as an agenda. That way I think we will get some action, and I am convinced that good commission-committee activity is really the basis of an effective association. I even wonder whether the president should exercise any persuasion in selecting the chairmen of commissions. I have been given the idea for some, the selection of chairmen is a somewhat casual matter. In fact, I think that in some cases a man who is not in attendance has been elected chairman, and this may not be the ideal thing.

In this connection, secondarily, I also invite recommendations from you as to the objectives and the projects which the association in the near future expects to pursue. I have been very much impressed with the meeting of the Society Officers Conference which the society president reactivated this year and with the many and very progressive steps that we have taken this year and I think this should be continued. What the theme the next year should be, I think the Council should cooperate in determining and the priorities of last night's meeting—particularly Dr. Reid's comments are very stimulating. I think we have got to do this. We have to exercise leadership.

I think the job as president is somewhat of being a shepherd; you've got to lead the flock at this, prod a few, and cajole a few others, and you've got to be father to a few, and I'm going to try to measure up to this. Now, I would like to lay down the guidelines for the coming year, knowing that the percentage of accomplishment may be very low, at one of the meetings of the annual meeting.

I am taking one of the weeks off of this month to write the President's Page— I hope for the whole year. And my idea, and I haven't talked to the president about it, would be the topical matters—the urgent matters will be much more expeditiously dealt with in the Newsletter, and a continuing philosophical type of thing might be helpful in the President's Page this year. I'm going to try to block this out and try to get it out of the way. I think my predecessors would appreciate this and it would be a great relief too, to me in this current year.

I'd like to mention too that the president delegated me together with Mr. Waggener to be responsible for a presentation to the State Congressman's hearing for matters to present to the Democratic National Committee platform. Last week, Dr. Black, I deputized him as Dr. Larson's deputy to do this, and he and Jim drew up what I think is an excellent statement. It is available to you if you want to read it of the various things to be presented to the Platform Committee to go to the Democratic National Committee. Most of you know that Dr. Wood did this for the Republican National Committee in a very masterful way.

Finally, in conjunction with the appointment of the new committees, I would like to remind those of you who know about it and to inform those of you do not know about it that the San Francisco AMA meeting appointed a committee known as an Advisory Committee to Health Care. This committee was made up of various groups, who it is hoped might help medicine in many ways. One of the corollaries of this action was the recommendation by the AMA that state associations do a similar project and appoint a committee in the state. I have cleared this with Dr. Larson and Dr. Steen, and I would like to ask the Council for authorization to proceed with formulating a committee similar to this AMA committee on a state basis which would be appointed for a year concurrent with the new terms to be activated or to be announced at the annual meeting. I have this item in the *AMA News* if any of you want additional data on it, in the expectation that many of you are conversant with it. Mr. Chairman, I would move that the Council authorize the creation of such a committee, and that I be permitted to appoint such a committee.

DR. STEEN: Is there a second? Seconded by Dr. Kerr and several others. Discussion? Those who favor the motion signify by the usual sign. (Response-ayes). Opposed? So ordered. Mr. President-elect you may proceed with the appointment of such a committee.

DR. CORCORAN: May I supplement that I would welcome suggestions from the Council on nominees for that, too.

DR. STEEN: Mr. President-elect, might I suggest that you direct a communication to the councilors requesting such suggestions.

DR. KERN raised the question about the working relationships between the councilor and the alternate councilor and their respective responsibilities within their districts. This was discussed by Dr. Steen and others and Dr. Taylor called attention to the fact that the Constitution specifies the fact that the councilor will visit each constituent society within his district once each year.

DR. BIBLER gave a brief report on the activities of the AMA and the recent election, and expressed his appreciation for the assistance given him in his campaign for re-election to the board of trustees by the members of the Council and the membership of the ISMA.

DR. DONATO: I move re-consideration of action taken Saturday night in regard to legal counsel and on roll call vote it was agreed to reconsider the previous action and the Council adjourned to executive session.

(Following executive session, the Council reconvened).

Dr. Larson commented he felt there should be a joint meeting of the AMA delegates and alternate delegates in the very near future. Upon motion of Dr. Taylor and seconded by Dr. Kerr it was agreed that this be done at the meeting in Fort Wayne.

There being no further business the Council adjourned to meet again at Fort Wayne at 2:00 P.M., Monday, October 14. ◄

THE COUNCIL

October 14, 1968

The Council convened at 2:00 p.m., Eastern Standard Time, in the auditorium of the Chamber of Commerce Building in Fort Wayne, Indiana on October 14, 1968, with Dr. Lowell H. Steen, the chairman presiding.

Roll call was recorded as follows:

Councilors:

First District—Gilbert M. Wilhelmus, Evansville, present.
Second District—Joe Dukes, Dugger, present.
Third District—Donald Kerr, Bedford, present.
Fourth District—Robert M. Reid, Columbus, present.
Fifth District—Wilbert McIntosh, Riley, present.
Sixth District—Stephen D. Smith, Knightstown, present.
Seventh District—Albert M. Donato, Indianapolis, absent.
Eighth District—Donald R. Taylor, Muncie, present.
Ninth District—Peter R. Petrich, Attica, present.
Tenth District—Lowell H. Steen, Hammond, present.
Eleventh District—Lowell J. Hillis, Logansport, present.
Twelfth District—William R. Clark, Fort Wayne, present.
Thirteenth District—Otis R. Bowen, Bremen, present.

Alternates:

First District—Eugene W. Austin, Evansville, absent.
Second District—Betty Dukes, Dugger, present.
Third District—E. L. Wallace, New Albany, absent.
Fourth District—Jack E. Shields, Brownstown, present.
Fifth District—C. M. Schauwecker, Greencastle, absent.
Sixth District—Frank H. Green, Rushville, present.
Seventh District—John O. Butler, Indianapolis, present.
Eighth District—Paul W. Sparks, Winchester, absent.
Ninth District—Clarence G. Kern, Lebanon, absent.
Tenth District—C. T. Disney, Gary, present.
Eleventh District—James A. Harshman, Kokomo, present.
Twelfth District—Frederic L. Schoen, Fort Wayne, present.
Thirteenth District—G. Beach Gattman, Elkhart, present.

Officers:

G. O. Larson, LaPorte, president
Patrick J. V. Corcoran, Evansville, president-elect
Lester H. Hoyt, Indianapolis, treasurer
Malcolm O. Scamahorn, Pittsboro, assistant treasurer
Frank B. Ramsey, Indianapolis, editor, *The Journal*

Executive Committee:

Ralph V. Everly, Indianapolis, chairman
Burton E. Kintner, Elkhart, member

Delegates and Alternate Delegates to the AMA:

Harold C. Ochsner, Indianapolis, absent.
Eugene F. Senseny, Fort Wayne, present.
Frank H. Green, Rushville, present.
Guy A. Owsley, Hartford City, present.
Jack E. Shields, Brownstown, present.
Don E. Wood, Indianapolis, absent.
Robert M. Brown, Marion, present.
Kenneth O. Neumann, Lafayette, present.
Maurice E. Glock, Fort Wayne, absent.
Dwight W. Schuster, Indianapolis, absent.

Guests:

Glenn W. Irwin, Jr. Indianapolis, Dean, Indiana University School of Medicine, present.
A. C. Offutt, Indianapolis, State Health Commissioner, absent.
E. F. Megenhardt, Indianapolis, Professional Advisory Committee, Blue Cross, absent.
Glen V. Ryan, Indianapolis, chairman of the Board, Mutual Medical Insurance, Inc., present.
Charles H. Aust, Fort Wayne, chairman, Convention Arrangements Committee, present.
Myron H. Nourse, Indianapolis, alternate delegate, AMA Section on Urology, absent.
Sprague H. Gardiner, Indianapolis, alternate delegate, AMA Section on OB-GYN, present.
Lall G. Montgomery, Muncie, delegate, AMA Section on Pathology, absent.
James H. Gosman, councilor-elect, Seventh Medical District, present.

Staff:

Howard Grindstaff, field secretary
J. A. Waggener, executive secretary
James J. Stewart, Indianapolis, attorney

On motion of Dr. Taylor and seconded by Dr. McIntosh, the minutes as distributed of the August 17th meeting were approved.

Reports of Councilors

Doctor Corcoran, reporting in the absence of the councilor and alternate councilor of the First District, said everything in the district was in order.

Doctor Dukes report for the Second District was in proper order.

Doctor Kerr in the Third District reported everything was in order and their meeting in 1969 would be held in New Albany on April 2nd.

Fourth District, Doctor Reid, no report.

Fifth District, Doctor McIntosh, no report.

Sixth District, Doctor Smith, no report.

Seventh District, no report.

Eighth District, Doctor Taylor reported that their 1969 meeting will be held in Muncie on June 4th.

Ninth District, Doctor Petrich announced that their 1969 meeting would be held May 22nd in Lafayette.

Tenth District, Doctor Steen introduced Dr. Vincent J. Santare as councilor-elect from the Tenth District, to replace Doctor Steen whose term is expiring with this convention. He also introduced Dr. C. T. Disney, the alternate councilor to fill the unexpired term of Dr. Herman Wing.

Eleventh District, Doctor Hillis announced the 1969 meeting will be held September 17th at Marion, Indiana.

Twelfth District, Doctor Clark announced the 1969 meeting will be held on May 21 and will be held in Fort Wayne.

Thirteenth District, no report.

Reports of Guests

The chair called upon Dr. Glenn W. Irwin, Jr., Dean of the I.U. School of Medicine.

DR. IRWIN: 1968 is the 60th year for the school of medicine as a four-year school and in that time we have graduated almost 6,300 students. Last year we led the nation from the standpoint of entering medical students. The entering class was 221. The total enrollment for the four years was 841, which was also the largest in the country. In June of 1968 we graduated 209 students.

I think you might also be interested to know that the present freshman class has been increased by five. The current class totals 226 this year. This class comes from 18 Indiana schools and 26 different out-of-state schools, but there are only 14 out-of-state students in the class. Indiana University had 80 of our freshmen this year; Wabash had 24, ranking second. This was a major increase for Wabash. Purdue ranked third with 13 students; Notre Dame fourth with nine students; Indiana State fifth with seven students; and Butler and DePauw ranked sixth with five students.

Also, perhaps you would be interested to know from what part of Indiana these medical students came. Marion County had

the largest group of 33; Lake County ranked second with 21; Allen County ranked third with 17; St. Joseph and Monroe were fourth with nine each; Elkhart fifth with eight; Madison and Vanderburg sixth with seven each. In making an analysis of the background of these students, we found that in this class 37 students have fathers who are business executives. Small businessmen were next with 36 students, the second largest group. Physician fathers were next with 31. This is a marked increase from last year when only 15 of that class were sons of physicians. From then on it drops way down to a variety of categories. It is interesting to note that 31 of these freshmen have earned letters, many of them with distinction in varsity athletics. Thirty-two of them were class officers. Five of them are veterans.

This past year the Admissions Committee had probably its most difficult year in history. There was a larger number of applicants and a tremendous increase in the number of qualified applicants. The Admissions Committee is composed of 15 members who are in the private practice of medicine and 15 who are full-time faculty members. Of the 15 who are full-time faculty, seven have Ph.D. degrees and eight have M.D. degrees.

There were 1,018 individuals who applied for admission this last year, including 460 Indiana residents. This year we put 20 on the alternate list because it was felt these students were exceptionally well qualified. At the last moment, after extensive negotiations with the faculties and administrations of the other state universities and Notre Dame, five students were permitted to begin their medical school work at Notre Dame and Purdue. Distribution of the first year class is now 197 entered at Indianapolis; 24 at Bloomington in the Medical Science Program; and 5 at Purdue and Notre Dame.

I might report to you that the Indiana Statewide Program is making rapid progress. Additional equipment has been ordered so that we hope to have this system complete and in full operation in a very short time. Approximately 30 persons, including directors of medical education, other physicians and staff throughout the state are either being completely or partially funded under the statewide program. The school of medicine has encumbered over $700,000 for physicians and their staffs in 14 communities throughout the state. Twenty-nine TV color tape recorders with television sets are located in 14 different cities.

I hope that county societies and hospital staffs will take an interest in the recent questionnaire sent out concerning the development of elective courses for medical students. I would like to stress that family practice programs can be made more appropriate at the community level than at the school of medicine campus.

This past year has seen an increase in interns. In 1967 we had 117 interns in the state of Indiana and in 1968 we have 139. This is an increase of almost 19% in one year. In 1967, we had 311 residents throughout the hospital system of Indiana and this year we have 348, which is an increase of nearly 12%. We therefore feel that the Indiana Plan is beginning to pay off and that the medical students are being exposed to a good practice of medicine.

We would just like to mention the finances of the school to inform you that the operating budget of the 21 departments this year was $15,643,000. Of that, approximately 45% came from general university funds; and approximately 55% from private or federal funds. Private funds amounted to 9% this year. While this is a big budget, I want to tell you that Indiana ranks last in the midwest, so far as state support per medical student. In Indiana it now costs about $5,000 per year per student, so we do have a problem and we would ask your support of our budget in the forthcoming session of the state legislature.

Two common questions often asked are: "How are you going to get more doctors into the system?" and "How are you going to expand medical education?" I am hoping that through the Indiana program that we can develop first year medicine programs at some of the other state schools and on some of the larger regional campuses so that after this first year these students could be transferred to the Indianapolis campus to complete their training.

I would like to extend to the Council an invitation to meet with the Medical School Alumni in January for a full day's session so that we might develop a better understanding of what is going on in the medical school, its activities and its program.

Thank you.

DR. STEEN: If there are no other questions, I will call on Dr. Glen V. Ryan, chairman of the board of Blue Shield.

DR. RYAN: I had the pleasure of representing the Indiana plan at a combined business meeting and program conference in Chicago this past week. The Indiana Plan is fortunate that the House of Delegates of the Indiana State Medical Association adopted Resolution 26 a few years ago making it possible for us to enroll members on the usual and customary fee concept. This has not been true with many of the other plans and I would like to report to you that an amendment to the membership standards was adopted which was presented at the National Association of Blue Shield meeting which reads as follows:

"Each active member plan shall make available the paid in full program based upon the usual, customary and reasonable charges of physicians and which takes into consideration the pattern of charges for similar services provided under comparable circumstances in the same geographic area. Such programs shall show evidence of professional support and shall contain provisions for the development and maintenance of individual physician's charge patterns. It shall have regular professional review and analysis consistent with plan responsibilities to both physicians and the general public."

Another proposal which will be submitted at the business session in April, 1969, reads as follows: "A plan shall have substantial support of the medical profession, evidence of which shall be approval of the plan by the appropriate medical society or societies."

The second thing which I wish to mention is Title XIX. This Council has previously taken action requesting Blue Shield to make a bid to act as fiscal administrator for this program. I want to report to you that we are formulating plans that if this law is enacted, Blue Shield will make a bid for it.

Next I would like to discuss with the Council the matter of Blue Shield board membership. The Blue Shield board Constitution and Bylaws calls for a board of 25 members. At the present time the Constitution provides that thirteen members of this board shall be physicians elected from their medical district; six members of this board shall be physicians elected at large and nominated by the Indiana State Medical Association. We now have 24 members on this board. Therefore, we have five non-medical members and I would like to name them: Mr. Stanley from the Delco-Remy plant in Anderson; Mr. Harold Rasmussen, a representative of the U.S. Steel Workers; Mr. Prentice Browning, president of American Fletcher National Bank; Mr. Frank Hoke of Holcomb and Hoke, and Dick Kilborn, president of Blue Shield. Over the country most Blue Shield plans have only 50% representation of physicians on their board and this is a matter of requirement by the state insurance commissioner.

Some time in the past, the Council made a motion that the existing vacancy on the Blue Shield board be a status quo situation. I would make an appeal to you that

we do not wait until pressure is put on us to force us to include additional non-medical personnel as members of our board. Therefore, I request your action to give us the authority for the board to appoint another non-medical member to the board. Thank you.

DR. STEEN: Doctor Ryan, we will take this particular request up under the Report of Council Committees because I know there are some who would like to comment on this matter. Before you leave the podium, does anyone else have a question to pose? If not, thank you for coming today.

DR. STEEN: Doctor Megenhardt is not here so Doctor Taylor will make Doctor Megenhardt's report at the time the Council liaison committee makes their report, of which Doctor Taylor is the chairman.

DR. STEEN: Since there is no unfinished business to come before the house, we will now hear the remarks of the president, Doctor Larson.

Reports of Officers

DR. LARSON: Mr. Chairman, members of the Council: Whatever the accomplishments of our association have been during the past year they have taken place as a result of teamwork. May I take this opportunity to express my deep personal sincere and heartfelt gratitude to all of you gentlemen on the Council, to the members of the Executive Committee, to the AMA delegates and their alternates and specifically to the members of the Commission on Convention Arrangements and the members of the Allen County Medical Society, who are our hosts for this meeting this week.

At this time also I wish to commend most highly our headquarters staff: Jim, Ken, Howard, and Bob and the 11 or 12 girls we have working our headquarters staff. Their help and their work is truly remarkable and I believe sincerely that there is not another state association in this country that has a staff that can compare with ours. I'd like to give the staff a hand at this time.

Now there are two items concerning which I wish to speak briefly. One of them has already been taken care of in the report that Dr. Ryan made. It is my feeling that the Council at this meeting today should take some action to clarify the matter which Dr. Ryan brought before us. The other matter I shall mention very briefly.

During the past year I have attended two meetings during which there was unpleasant confrontation and demonstration with certain elements of our society. Now I anticipate no such incidents here in Ft. Wayne. However, in case such a thing should happen while we're here, I feel that you should know that I consider it my prerogative, and legal counsel has confirmed this, to at any time call for a recess. That I intend to do should any unfortunate incidents occur. We'll try to iron out any troubles between any demonstrators and the proper committees of our House of Delegates. I guess you have to, if any incident does take place, "keep your cool" and try and keep the rest of the members of the House quiet in the location in which you're sitting so that we'll have no difficulty. I hope and I sincerely feel that we will have no difficulty but I just wanted you to know that your officers have tried to consider the best means of handling such an incident should it occur.

Again gentlemen, my heartfelt thanks for your cooperation. It has been a real privilege to work with all of you. That's all I have to say. Thank you.

DR. STEEN: Under the announcements at the beginning of the meeting, I neglected to introduce to you our new legal counsel, Mr. James J. Stewart, who is with us today. Mr. Stewart.

DR. STEEN: And now we proceed to the address and the report of the president-elect, Dr. Patrick J. V. Corcoran.

DR. CORCORAN: Mr. President, Mr. Chairman, members of the Council, I have little to report. I've spent a lot of time trying to get commission appointments worked out because I'm convinced that good commission activity is one of the keystones of effective association functioning. I have had many suggestions, including reports from all except three of last year's commission chairmen. A number of the councilors sent comments and suggestions. In every instance that a councilor asked for an appointment, it was made, unless it involved a member being on more than one commission. I've invited men who preferred to serve on another commission to resign from the one in which they presently had office. I believe councilors or alternate councilors can't be fully effective if they also serve on a commission because of conflicting dates of meetings. Most of the appointment letters have been sent out. I plan to designate temporary chairmen to organize each of the commissions. In some instances, I will ask the Council to authorize me to replace men who have not been effective or active and who have yet to complete a term.

I want to acknowledge the cooperation which I have had this past year. I had no idea of the extent of the responsibilities which are involved in being president. Go-Go has been a tremendous teacher. I've told him more than once how well his own experience has paid dividends. You don't walk into this office and do it well without having had some seasoning, and he has done, I think, a remarkable job. I hope we'll go on and keep the momentum we have generated and carry out many of the constructive things he has initiated. I have devoted attention and soul-searching to the role of president. The part of the Bylaws which say that he shall be "the real head of the profession of the state during his term of office" is tremendously sobering and a challenging concept. There are so many features that are involved: one must be alert to the possible future trends and developments, and stay as informed as one can, studiously aware of the lessons of the past; you have to restrain the impetuous and foolhardy on the one hand, and, on the other hand, you may have to prod the laggards and stimulate the indifferent, and above all be patient in listening to everybody. It's amazing what you can hear if you listen. On those premises, I'll try to do what I can. I hope you will continue to give me the cooperation all of you have shown me as a councilor and bear with my temperament—I blow hot, but I don't stay hot for very long. Thank you very much.

DR. STEEN: Thank you, Mr. President-elect.

DR. LARSON: May I just make one additional remark? This remark is made for your information only, gentlemen, and I am no different from the presidents of your society for a good many years. To date this year I have spent 104 days on association business when I have been out of town. I just thought you might be interested in that figure.

DR. STEEN: We shall now hear the treasurer's report.

DR. HOYT: The report in the delegates Handbook of course is a report of last year's audit because this year's report has not been completed as yet. However, I do have the late figures here as of September 30th which show general fund assets $273,000 and the liabilities are $82,000, making a net of $190,000 compared to $177,000 last year. *The Journal* fund net income totals $4,000, which is a

little bit better than last year. The defense fund is down a little bit, $27,000 compared with $32,000 last year. The student loan fund is $14,897. Now this is one which will always confuse everybody. There is a section in the Handbook on page 111 which you can read in your spare time if you are confused about the student loan fund.

Our income was a little less than the budget but our expenses were even more under budget so that we are in the black $23,000. We were budgeted for $13,000 in the black so we beat the budget by $10,000. As far as investments are concerned, we bought $25,000 worth of Johnston Mutual funds and we have a report of dividends, as of September 27th, amounting to $78.90. The price we bought it was $22.18 and the price as of that date was $23.17. I believe that concludes my report, unless there are some questions.

DR. STEEN: Does anyone have a question to ask of Dr. Hoyt? If not, Dr. Hoyt, I believe it is appropriate that you move that the treasurer's report be adopted.

DR. HOYT: I so move.

DR. STEEN: Moved by Dr. Hoyt and seconded by Dr. Petrich—called for discussion. There being none, all in favor signify by saying "aye." Opposed. So ordered. We will now hear from Dr. Frank Ramsey, editor of *The Journal.*

DR. RAMSEY: Mr. Chairman, members of the Council: Dr. Hoyt mentioned that *The Journal,* at the close of the year, finished with more revenue than we had expense. Advertising income was almost as good as last year and income from advertising was good compared with almost any other journal including the national journals. It was down and did not come up quite to what we thought it should. On the other hand, the printing bill was not as high as we thought it would be.

We are entering the new fiscal year this month—revenue will be subject to internal revenue tax. We do not know yet, pending a legal decision on the matter, as to what expenses we may deduct from our gross revenue to arrive at a taxable amount. If we are able to deduct all *The Journal* publication expenses from the advertising revenue, then we will pay very little in the way of taxation. If we are allowed to deduct only a portion of the expenses in relation to the proportion of advertising carried in *The Journal* and are not allowed to deduct the costs of the editorial matter, then this will probably greatly alter the entire financing background. I would like to tell you that the Indiana Cancer Society awarded the association and *The Journal* a citation at their annual banquet this last week in recognition of the support which the association and *The Journal* had given the anti-cancer campaign.

DR. STEEN: Thank you, Dr. Ramsey. Does anyone have any questions? If not, we will now have a report of the delegates to the American Medical Association.

Delegates to AMA

DR. OWSLEY: Mr. Chairman, some of you will remember that Indiana introduced a resolution in Houston to amend the Constitution and Bylaws of the AMA to provide that the vice-president be a voting member of the board of trustees. This was urged by Dr. Jones when he was vice-president. The resolution was adopted and referred to the Council on Constitution and Bylaws.

The Council, in formulating the change to make it legal, recommended that it not be implemented. This is a rather unusual action but nevertheless the report of the Council to the House of Delegates was considered by the reference committee. The reference committee likewise recommended that it not be implemented. Not knowing whether there was a change in the feeling of the association, I asked for the floor and was able to get a postponement until the meeting in Miami. The delegates have not been told of any new policy which might come about at the association level as a result of this action.

I wonder if it would not be well for the Council to define the present policy of the association and notify our delegates so that we can be doing our homework. I have a feeling it will be rather difficult to get this resolution through the AMA House of Delegates.

DR. STEEN: What is the desire of the Council with regard to the policy on this matter? Dr. Corcoran.

DR. CORCORAN: I would like to ask the chairman of the delegation to express his personal opinion as to whether it is possible or if there is reasonable possibility of getting this through in Miami.

DR. OWSLEY: Of course this is a hard question to answer. The Council on Constitution and Bylaws makes a recommendation to the reference committee in spite of the fact that it has been charged with the implementation of a resolution and the association comes back to the house and asks that this action be rescinded. I'm afraid we are in trouble. I'm not sure this is a good resolution anway. It is of course boring for the vice-president to sit there all year and not have a vote. One thing the opposition points to is that this would make an even vote on the board of trustees and with an even vote you are going to get into difficulty. If you want my recommendation, I'd say that it might be prudent for Indiana to ignore the resolution.

DR. STEEN: Members of the Council, what is your pleasure on this matter? Dr. Dukes.

DR. DUKES: I'll agree with him. Do I understand that you move that we withdraw the resolution of 1967? I so move. (Seconded by Dr. Wilhelmus.)

DR. STEEN: Is there further discussion? Those in favor of the motion to withdraw our previous resolution to give the vice-president of the American Medical Association a vote signify by saying "aye." Opposed. There is a solitary nay vote. The motion is carried and we will instruct our delegation to withdraw the resolution. Dr. Shields.

DR. SHIELDS: Does this mean that we are to oppose this resolution?

DR. STEEN: I think the essence of this discussion here is that we will not work toward the passage of this resolution, rather than actually withdrawing it. And if it is agreeable with the councilors, we will take the prerogative of making an editoral change and say that we will not work toward the passage of this resolution instead of the motion as it passed.

Discussed further by Dr. Petrich, Dr. Owsley and others.

Matters Referred by the Executive Committee

DR. STEEN: We will now move on to Item H—Matters Referred by the Executive Committee, Dr. Ralph V. Everly, chairman.

DR. EVERLY: Gentlemen, the Executive Committee refers to the Council the matter of the time and location of the 1969 convention and we would like to have the Council approval of the Executive Committee's suggestion of using the Columbia Club as the headquarters. We have given thought, of course, to other places but it is our opinion that the Columbia Club would be the place and we would like to have confirmation from the Council.

DR. TAYLOR: I move that we utilize the Columbia Club as the headquarters. Seconded by Dr. Bowen and Dr. McIntosh.

DR. STEEN: Is there further discussion? Dr. Corcoran.

DR. CORCORAN: I am wondering if we should consider using the newly renovated Atkinson Hotel. Our legal counsel, Mr. Stewart, told us that he had attended a meeting in the new Atkinson, which has been refurbished at great expense, and it is reported extremely beautiful. Mr. Stewart informs us that it compares with hotels of such cities as Chicago, New York and San Francisco. Some councilors stay at the Stouffer Inn when we are in Indianapolis;

and I might say a very pleasant feature of the Council meeting occasionally takes place later among the peanut shells.

DR. STEEN: We now have a motion on the floor to make the Columbia Club the headquarters. Is there further discussion? (Further discussed by Dr. Dukes, Mr. Stewart, Dr. Wilhelmus and the executive secretary). The motion was put to a vote and carried with one opposing vote to be shown in the record as being by Dr. Dukes.

DR. EVERLY: The next item, gentlemen, the dean alluded to this subject when he mentioned a joint meeting of the Council and the Alumni Association of the Indiana University Medical School. Dr. Steen attended a joint liaison meeting with I. U. officials and he went to great length this morning telling the Executive Committee about the situation as it exists. It was suggested by the dean that the Executive Committee and the Council set aside a day when we would have a joint meeting at the Indiana University School of Medicine. They have suggested Sunday, January 12, 1969.

DR. STEEN: The dean has been requested by the Alumni Council to arrange such a meeting which I believe should be attended by the members of the Executive Committee, the councilors and the alternate councilors, so you too can know what is going on in depth at the Indiana University School of Medicine. The date of this meeting is not subject to controversy, change, or decision. This is the date of the meeting. The question is whether you wish to or do not wish to accept the invitation and I would first like to call upon the chairman of the joint liaison committee, Dr. Petrich of Attica, Indiana to comment.

DR. PETRICH: This is a continuation of our effort to bring a closer working relationship between the university and this association and I heartily endorse the acceptance of this invitation.

I further move that we accept this invitation and furthermore that the association pick up the tab for the lunch. Seconded by Dr. Hillis.

DR. STEEN: Is there further discussion? If there is no further discussion, those in favor of the motion signify by saying "aye." Opposed. So ordered. Thank you, Mr. Chairman of the Executive Committee.

Economic and Organization Matters

DR. STEEN: We will now move to Item I—Economic and Organization Matters. We will hear a report on the membership. Mr. Secretary.

MR. WAGGENER: You will note as of September 30, 1968 we have an increase of 13 members over the same period last year. We have likewise shown an increase in the AMA membership, having gained 49 more than we had in the same period last year. I believe it is the opinion of the Executive Committee that part of this increase in numerical strength at this time is due to direct billing.

DR. STEEN: Thank you, Mr. Secretary. We have for discussion the election of two members to the Subcommittee of the Indiana Medical Education Foundation. We notice that the terms of Dr. Robert B. Pickett and Dr. Jack Hall both expire in October, 1968. Are there nominations to fulfill the terms expiring in October, 1971? By motion duly made and seconded, Dr. Joe Dukes was nominated and elected to fill the term of Dr. Robert Pickett. Are there nominations for the spot held by Dr. Jack Hall? By motion of Dr. Kerr and seconded by Dr. Hillis and McIntosh, the nominations were closed and Dr. Hall was declared reelected.

The Journal

DR. STEEN: Item 3 on the agenda is the election of two members to the Editorial Board of *The Journal.* The terms of Dr. Alvin Haley of Ft. Wayne and Dr. Wei-Ping Loh of Gary expire this year. By motion of Dr. Clark and seconded by Dr. Wilhelmus, Dr. Haley was nominated to succeed himself and upon motion of Dr. Kerr and seconded by Dr. McIntosh, the nominations were closed and Dr. Haley was declared reelected. On motion by Dr. Kerr, Dr. Wei-Ping Loh was renominated and Dr. Petrich moved the nominations be closed, seconded by Dr. Hillis, and Dr. Wei-Ping Loh was declared reelected to succeed himself.

We will now move to Item 4—the election of the Editor and two Associate Editors of *The Journal.* Upon motion of Dr. Hillis and a second by Dr. Petrich, it was moved that the incumbents succeed themselves. Dr. Kerr moved the nominations be closed, seconded by Dr. Petrich, and the incumbents were elected to succeed themselves.

Matters from Committees and Commissions

DR. STEEN: We will now move to reports of commissions and committees and I call on Dr. Charles Aust of Fort Wayne, chairman of the Convention Arrangements Committee. Dr. Aust.

DR. AUST: Mr. Chairman, members of the Council, members of the state medical association staff, and other guests. It is my privilege to welcome you to Ft. Wayne. I don't know if anyone has done that and we don't want to be remiss. We are happy with the program. We hope you folks are happy with Fort Wayne. We have had unusually good cooperation from our local medical society, Dr. Schoen is here, as well as our local councilor, Dr. Clark, who has been most helpful to us. Also our AMA delegate and alternate, Dr. Senseny and Dr. Glock, have been most helpful. It is my hope that this will be an enjoyable week for all.

DR. STEEN: Thank you, Dr. Aust, and I think the Council, as the responsible body for what goes on in the association, should move to give Dr. Aust and his entire committee a rousing hand for his excellent work. I would like now to call on the secretary for a report on the exhibit space.

MR. WAGGENER: We have 69 companies in the exhibit hall for a total of $17,000 this year. Compared with Indianapolis in 1967, we had an income of $16,635. In 1966, $11,975 and 1965, $18,934. I will also announce that this is the first time we raised the exhibit booth area rent from a top of $225 to $300.

DR. STEEN: Thank you, Jim. At this point I would like to ask specifically that all those in this room, particularly councilors and alternate councilors, to please go by and visit every exhibit space and express your thanks to the exhibitors one way or the other for attending our meeting.

DR. STEEN: We will now move on to the resolutions to be presented from the Council. Let's discuss Resolution 68-25, Representation on the Admissions Committee at the Indiana University School of Medicine. After a full discussion, on motion of Dr. Hillis and seconded by Drs. McIntosh and Taylor, it was voted to present the resolution to the House of Delegates as written.

By consent it was agreed that the resolutions on Implied Consent and the Indiana Medical Foundation be presented as written.

DR. STEEN: Dr. Taylor wants to discuss the report of the Commission on Constitution and Bylaws. Dr. Taylor.

DR. TAYLOR: On page 126 of your Handbook I notice the Commission on Constitution and Bylaws is recommending a change by adding a Section 9 which has the effect of limiting the terms of physicians on the Blue Shield board to two consecutive terms of three years each. I think our present policy is that they can serve for four terms, or a total of twelve years. I think the Council acted upon that a year or so ago.

Well the thing that bothers me and I'm sorry I didn't know that the House had taken this action or didn't remember, but allowing a man to serve only six years on that board of directors seems to me like

somewhat of a mistake.

This item was discussed by Dr. Neumann, Dr. Harshman, Dr. Kerr and Dr. Taylor.

DR. STEEN: Dr. Taylor has moved that the Council approve recommending to the reference committee that the term in the Bylaws be changed to three three-year-terms rather than two three-year-terms. Seconded by Dr. Petrich, put to vote and carried.

Matters From Council Committees

DR. STEEN: We will now move to matters from the Council Committees—Item 1, Council Committee with Blue Shield. Dr. Kerr.

DR. KERR: We have four items for consideration. One—the liaison committee was directed to find out what we could do about the six months shut off date on welfare patients which was just inaugurated last year. We have requested that this be extended to a full year and have been informed that this is a decision that must be made by the state welfare board.

The second item—I understand that they plan to issue checks after the first of January directly to physicians and not to double endorse it to physicians and patient, as in the past. This has come about in part because of a rather phenomenal number of forgeries on the part of the patients. This is a matter we should watch. As you know, we keep talking about third party intervention and have kept saying in principle that the patient should be responsible. We have to watch that we are not talking out of both sides of our mouth.

There is another matter brought to my attention by the chairman of the Council. I think that a bouquet is due him publicly —I am talking about Mr. Kilborn—the president of the Blue Shield Plan. In Washington when all Blue Shield Plans met with HEW there was a double-barreled proposal. One is that the Blue Shield Plan should pay HEW for the use of some of the information which they have acquired relative to Medicare patients and when they have used this information in the sale of supplementary plans. They also asked apparently that all the fiscal information which Blue Shield Plans have acquired relative to what you and I do and how much we do it for, should be turned over to HEW. I am told that of the 33 Blue Shield Plans represented, 31 voted not to give the information to HEW and a threat was made to take it all the way to the Supreme Court, if necessary, and that Mr. Kilborn was one of the first and most vociferous to be on his feet and to argue for denial of this information to HEW.

You will recall at the last meeting we discussed the vacancy on the Blue Shield board and the Council took action that we should do nothing about filling this vacancy at the present time. You have heard Dr. Ryan give his expression of the problem of the need for satisfying several in appointing a non-medical person to the Blue Shield board. In view of the information which you have received, I think it is incumbent upon this Council now to express to your liaison committee what we desire the Blue Shield board to do.

DR. STEEN: I believe that inasmuch as your own committee has not met to consider this and have a recommendation at this time to the Council, that we will defer this matter until you have an opportunity to call your committee together to discuss this and bring a recommendation in to us.

If there is no further comment on the report of the Blue Shield Liaison Committee, we thank you, Dr. Kerr, and we will move on now to the Liaison Committee with Blue Cross.

DR. TAYLOR: I have three items which I want to bring to your attention and I think they are rather important. First of all, Blue Cross-Blue Shield is starting on their construction program for a new building, as you well know. The first thing, of course, is the tearing down of the old structure and this has been started. You may have seen on the news that the eagles on top of the Traction Terminal Shed created quite a bit of interest to the people of Indianapolis and these were given to the Indiana State Museum and were moved there at the expense of Blue Cross and Blue Shield.

The second item I would like to discuss is a grant that is going to be given by Blue Cross to the Indiana State Association of Licensed Nursing Homes. This organization is employing a full-time executive director, who will be Mr. Albert Kelly, formerly director of the State Department of Public Welfare. This organization requested that Blue Cross help them in implementing their increased headquarters staff with a grant of $15,000 per year. The following action was taken by Blue Cross. They will underwrite any deficit in the '69 budget of the Indiana Association of Licensed Nursing Homes up to the figure of $15,000 and this basically, I believe, is to handle the expense of the full-time executive director. This is the second financial funding that Blue Cross has made this year. The first, you will recall, was to the Indiana Hospital Association, in order for it to increase its staff.

The third item I would like to report, is the action taken by the board of directors of Blue Cross on recommendation of the rate committee at their last board meeting. This expresses the feeling that Blue Cross should actively support the expansion of the health facilities planning councils throughout the state of Indiana. I have previously explained to you how local health facilities planning councils function in the determination of rates which Blue Cross allows various hospitals. Now they have taken action on a hospital up in the northeast part of the state, I can't remember just what city it was—this hospital had asked for approval of rates for new facilities which they were activating and the Blue Cross Rate Committee turned it down on the basis that it had not been approved by a regional planning council.

Dr. Neumann objected strenuously to this action, as did some others, but the board of directors, as a whole, passed the action with a minor amendment. So from now on, it would appear that when any hospital asks for new facilities to be rated by the rate committee of Blue Cross, unless it has been cleared by the regional council as well as the local council, it will not be approved.

The resolution introduced by the rate committee to support this action was as follows:

"Approved planning at the local level shall be superseded by the action of an approved regional planning council and, in the absence of an approved regional planning council, such shall be formed as promptly as possible."

The amended resolution as passed is:

"Approved planning at the local level shall be coordinated with that of an approved regional planning council and, in the absence of an approved regional planning council, such shall be formed as promptly as possible."

The report of Dr. Taylor was discussed by several and the chair thanked Dr. Taylor for doing an excellent job on this committee.

DR. STEEN: We will depart temporarily from the agenda to take up one matter so we will not forget it. If you had an opportunity to thumb through this compilation of data, we would like to defer it until breakfast tomorrow morning so as to go over this a little more before we take action. We will have one more report and then we will recess until breakfast tomorrow morning. Breakfast meeting is 8:00 a.m. in this building in the Canal Room on the main floor.

We will now call on Dr. Petrich, chairman of the Council Liaison Committee

with the Indiana University School of Medicine and then we will recess until tomorrow morning at 8:00 a.m. Dr. Petrich.

DR. PETRICH: The report is printed in the index and I don't have any more to add except to reiterate what has been said at the last meeting by the chairman, that I feel the invitation from the Alumni Council to this body is most important and further all of you who may be able to attend this council meeting on January 12th, plan now to be present. I would call your attention to corrections on page two of the report in paragraph one instead of $60,000, it should be $600,000 and in paragraph two, it should read "two way radio and one way television." Otherwise the report stands as printed.

DR. STEEN: Are there any comments? If not, we will stand recessed until 8:00 a.m. Tuesday, October 15th. ◄

THE COUNCIL

October 18, 1968

The Council convened for purposes of organization at the conclusion of the final meeting of the House of Delegates on Friday morning, October 18. The meeting took place in the Parlors of the Women's Club in Fort Wayne. It was called on the order of the president, Dr. P. J. V. Corcoran.

By secret ballot Dr. Donald R. Taylor of Muncie was elected chairman and Dr. Ralph V. Everly of Indianapolis and Dr. Burton E. Kintner of Elkhart were re-elected as members of the Executive Committee.

There being no other business except a few routine matters, the Board adjourned to meet again at 9:00 a.m., Sunday, November 17, 1968.

COMMERCIAL ANNOUNCEMENTS

BUY AND TRY: Wye Plantation Aberdeen-Angus frozen semen from Advanced Register P.R.I. sires officially goining over four pounds per day or whose 365-day weights are above 1,200 pounds. (Performance tested sires always for sale.) WYE PLANTATION, Queenstown, Maryland 21658. Telephones: 301-827-7166 or 301-827-7160.

WANTED: In a college community, on associate or portner for a lorge medical practice. No surgery or OB. General practice con be done if desired. X-ray and loboratory facilities in the office. If desired, will consider sale. Write Box 344, The Journol, ISMA, 3935 N. Meridion St., Indianapolis, Ind. 46208.

PEDIATRICIAN: Solary to $18,000 first year, portnership with 3 generol pediatricians second year. Midwest university town; 600-bed hospital; intern program. Contact L. L. Wince, M.D., Children's Clinic, 806 W. Jackson St., Muncie, Ind. 47305.

AVAILABLE: Medical suite. Established proctice in professional building, 6049 E. Washington St., Indianopolis. All services furnished. Phone R. C. Corson, 846-8524.

WANTED: G. P. for New Costle; replacement in four-man group. Starting guarontee at leost $35,000 first year; then partnership with increase. Rotating schedule; on duty less than 50% of the time. Call (317) 529-6250, Henry County Clinic.

WANTED: Two general practitioners to join two generol proctitioners in a lorge well-established practice of over 30 yeors in a town with population of 800 and covers large rurol area of opproximately 5,000. Locotion is 50 miles north of Minneopolis, Minnesoto in excellent fishing and hunting area with golf, bowling ond other recreation olso available. Hove local community hospitol, medicare opproved and equipped for general medicine and mojor ond minor surgery. Solary negotioble, partnership available. New clinic planned. For references contact Dr. Gerald Larson, Cambridge, Minnesota; Dr. Joe Halpin, Rush City, Minnesoto; Dr. Richord Varco, Dept. of Surgery, University of Minn. Medical School, Minneapolis, Minnesota; Dr. Dean Rizer, Internist, Medicol Arts Building, Minneapolis, Minnesota; Dr. Paul Larson, OB-Gyn, Medical Arts Building, Minneapolis, Minnesota. If interested send application and references to Brahom Clinic, Attn: Wm. T. Nygren, M.D., Broham, Minnesoto 55006 or phone areo code 612-396-3355 between hours of 10-12-A.M. or 1-5 P.M. Monday thru Friday. If after hours phone 612-396-2153. May coll collect. If occeptoble, expenses for personol interview will be ollowed.

PSYCHIATRIC RESIDENCIES: Starting July 1969. Approved troining in a mental institution with State of Michigon, Department of Mental Health. Three and five year programs avoilable. Salary $9,876-$11,233 and $11,254-$21,381. NIMH-GP stipends $12,000. Locoted in Michigon's serene, scenic recreation area on Grand Traverse Bay. For odditional informotion, contact Dr. Paul Kouffmon, Training Director, Traverse City State Hospital, Traverse City, Michigon 49684. An equal opportunity employer.

OPENING FOR INTERNIST, SURGEON, GENERAL PRACTITIONER: Huntington, Indiono. Huntington populotion 18,000. Approximotely 17,000 in the county. Locoted 25 miles southwest of Fort Wayne. 100-bed hospital. Fourteen doctors on the staff. The hospitol wos completely renovated and expanded in 1961, is well equipped with modern laboratory and x-ray, recovery room, intensive care unit, etc. Contoct Carl S. Smyth, Adm., Huntington County Hospitol, 1215 Etna Ave., Huntington 46750.

RADIOLOGIST, INDIANA, V.A.: Solary $20,000 to $23,000. Liberal fringe benefits. Write or coll Chief of Stoff, Veterans Hospital, 1600 Randolia Drive, Fort Woyne, Indiona 46805. An Equal Opportunity Employer.

OPENING FOR PSYCHIATRIST, UROLOGIST AND GENERAL PRACTITIONER (psychiatric or geriatric experience desirable but not essentiol). 1611-bed generol medical surgical ond psychiatric hospitol with excellent facilities and progressive stoff; an equal opportunity employer. Salary: $14,409.00 through $25,711.00 according to training and experience. Write to: Director, VAH, Donville, Illinois 61832.

FERRIS STATE COLLEGE needs two additionol full-time staff doctors for Student Health Center. New modern focilities including 31 bed infirmory. Excellent opportunity for quolified persons in smoll quiet college town. Regulor hours with rotating night and weekend call. Solary to $18,000 and excellent fringe benefits. Pleose contoct Roy A. Dovis, M.D., Area (616) 796-8463 or write in core of Ferris Stote College, Heolth Center, Big Rapids, Michigan 49307.

NINETEEN-MAN Wisconsin group locoted in college community of 40,000 with excellent hospitol focilities is seeking additionol ossociotes in the following oreas:

1. Internol Medicine
2. Urology
3. General Proctice
4. Pediotrics

For further information, please contact D. R. Griffith, M.D., Midelfort Clinic, Eau Claire, Wis. 54701.

EMERGENCY ROOM PHYSICIAN: Excellent opportunity for young physicion interested in full-time practice of emergency room care. Join a physician group responsible for the emergency service of two major Cincinnoti hospitals. Remuneration on a fee-for-service bosis with guaranteed minimum. Must hove or be eligible for Ohio license. Send resume to P. O. Box 36163, Cincinnoti, Ohio 45236.

NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

Charges for commercial announcements are:

First four lines: $3.00
each additional line: 50¢

Send cash with order. Average count: seven words to the line.

DEADLINE: Fifth day of month PRECEDING month of issue.

ADVERTISERS IN THIS ISSUE

December 1968 Volume 61 No. 12

Associated Credit Bureaus of Indiana 1673
Associates Investment Company 1639
Breon Laboratories, Inc. 1691
Brown Pharmaceutical Co. 1672
Burroughs Wellcome & Co., Inc. 1633
Coca-Cola Company 1680
Central Brace & Limb Co., Inc. 1698
Chicago Medical Society 1637
Dairy Councils of Indiana 1619
Fort Wayne Medical Society 1641
Geigy Pharmaceuticals 1634-35, 1648-50
Hanger, J. E., Inc. 1686
Harding Hospital 1690
Heid's Shoe Store 1688
Highland Hospital 1683
Hook's Drugs 1677
Hynson, Westcott & Dunning, Inc. 1613
Indiana Bell Telephone 1685
Indiana Brace, Inc. 1652
Indiana Medical Bureau 1647
Lederle Laboratories 1615, 1636, 1654, 1682
Lilly, Eli & Company 1622-23, 1644
Medical Protective Co. of Ft. Wayne 1692
Mutual Medical Insurance, Inc. .....2nd Cover
Parke, Davis & Company 1621
Pitman-Moore Company 1696-97
Poythress, Wm. P. & Co., Inc. 1684
Quality Leasing, Inc. 1689
Robins, A. H. Company, Inc. 1624, 1687
Roche Laboratories .....4th Cover, 1617
Roerig, J. B. & Co. 1654-55
Sandoz Pharmaceuticals 1653, 1663
Searle, G. D. & Co. 1694-95
Smith Kline & French Laboratories .....3rd Cover
Strasenburgh Laboratories 1656
Stuart Company, The 1693
Wabash Valley Hospital 1661
Warren-Teed Pharmaceuticals 1626-27

In accepting advertising for publication, *The Journal* has exercised reasonable precaution to insure that only reputable factual advertisements are included. However, we do not have facilities to make any comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services, and medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertiser only. Neither sanction nor endorsement of such is warranted, stated, or implied by the association.

The JOURNAL

of the

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

EDITOR

FRANK B. RAMSEY, M.D., Indianapolis

ASSOCIATE EDITORS

A. W. CAVINS, M.D., Terre Haute
DAVID A. BICKEL, M.D., South Bend
SAMUEL R. MERCER, M.D., Fort Wayne
LALL G. MONTGOMERY, M.D., Muncie
IRVIN W. WILKENS, M.D., Indianapolis

EDITORIAL BOARD

ALVIN J. HALEY, M.D., Fort Wayne
JENE R. BENNETT, M.D., South Bend
WEI-PING LOH, M.D., Gary
JACK W. HICKMAN, M.D., Indianapolis
FRANK H. COBLE, M.D., Richmond
W. D. SNIVELY, Jr., M.D., Evansville

ASSISTANT EDITOR

MRS. JACKIE FREERS STAHL, Indianapolis

BUSINESS MANAGER

JAMES A. WAGGENER, Indianapolis

Office of Publication: 3935 North Meridian Street, Indianapolis, Indiana 46208

INDEX TO VOLUME 61

January through December, 1968

January	Pages	1 to 154	July	Pages	953 to 1080
February	Pages	155 to 294	August	Pages	1081 to 1184
March	Pages	295 to 428	September	Pages	1185 to 1364
April	Pages	429 to 564	October	Pages	1365 to 1500
May	Pages	565 to 708	November	Pages	1501 to 1612
June	Pages	709 to 952	December	Pages	1613 to 1764

SCIENTIFIC ARTICLES

A New Solubility Test for Rapid Detection of Hemoglobin S (Loh) 1651
Acne Vulgaris, Management of, (Hackney) 1000
Air Travel, Medical Considerations for Patients in Commercial, (Stonehill-Murray) 1395
An Evaluation of the Psychological Aspects of Dropouts (Green) 1216
Angina Pectoris, Principles of Therapy in, (Elliott) 185
Arterial Lesions Due to Blunt Trauma (Glover-Waltz-King) 1403

Blood Dyscrasias, Drug-Induced, (Loh) 1125

Cancer Detection Examinations, The Case for Periodic, (Gilbertsen) 468
Cancer, Natural and Acquired Immunity to, (Hadley) 464
Cardiogenic Shock in Acute Myocardial Infarction (Dennison) 1537
Cardiopulmonary Patient, The Evaluation of the, for Air Travel, (Stonehill-Murray) 1531
Cholecystitis, Acute, The Surgical Treatment of, (Berman-Kimble) 733
Clinicopathologic Conference (Miller-White-Hubbard) 53
Clinicopathologic Conference (Steinmetz-Miller-Wilens) ... 475
Clinicopathologic Conference (Kleit-Miller-Wilens) 614
Clinicopathologic Conference (Fisch-Vellios-Bolinger) 1002
Clinicopathologic Conference (Behnke-Miller-Petty) 1423
Clomiphene Citrate, Ovulation Induction with, (Echt-Goodman) 986
Coarctation of the Aorta (Shumacker) 334
Commercial Supersonic Transportation and the Patient (Stonehill-Murray) 1645
Comparison of the Mono Test and the Heterophile Antibody Test (Russell-Ricchetti-Carlson) 984
Congenital Heart Disease, The Incidence of, in Adults at the Indiana University Medical Center, (Nasser-Feigenbaum-Fisch) 225
Cyst, Splenic, (Gitlin-Gitlin) 35

Death, Legal, What Constitutes, (Green) 1120
Depressive States, The Management of, (Nurnberger) 1416
Dropouts, An Evaluation of the Psychological Aspects of, (Green) 1216
Drug-Induced Blood Dyscrasias (Loh) 1125
Dymelor, Five Year's Experience with, (Hickman-Kirtley) .. 1114

Effective Office Management of Obesity (Allen) 1101
Electrocardiography, Pacemaker, (Fisch) 193
Endometriosis in a Case of Primary Hypogonadism (Cavins) 996
Epilepsy, Treatment of, (Green) 1118

Five Year's Experience with Dymelor (Hickman-Kirtley) .. 1114

Gallop Rhythm of the Heart: Current Concepts (Tavel) ... 208
Gastric Perforation, Idiopathic Neonatal: Report of Six Cases (Telle) 602

Hand Injuries, The Management of, (Wray) 486
Hemoglobin S, A New Solubility Test for Rapid Detection of, (Loh) 1651
Heterophile Antibody Test, Comparison of the Mono Test and the, (Russell-Ricchetti-Carlson) 984
Hodgkin's Disease, Radiotherapy of, (Scott) 459
Hypogonadism, Endometriosis in a Case of Primary, (Cavins) 996

Idiopathic Neonatal Gastric Perforation: Report of Six Cases (Telle) 602
Infections Encountered in Tornado and Automobile Accident Victims (Ivy) 1657

Management of Acne Vulgaris (Hackney) 1000
Masked Hypovolemia Following Open Heart Surgery (Stein-Knoebel) 231
Medical Considerations for Patients in Commercial Air Travel (Stonehill-Murray) 1395
Medical Problems After Open Heart Surgery (Stein-Knoebel) 205
Mononucleosis, Infectious, Treatment of the Exudative Tonsillar Phase of, with Oral Enzymes (Roller) 1411
Mono Test, Comparison of the, and the Heterophile Antibody Test (Russell-Ricchetti-Carlson) 984
Mucous Nasal Polyps Can Be Managed Non-Surgically (Rubin) 325
Multiple Sclerosis, The Treatment of, with Intrathecally Administered Methylprednisolone Acetate (Ringer) 1213
Myocardial Infarction, Acute, Cardiogenic Shock in, (Dennison) 1537

Nasal Mucosa, Significance of the Pale, Boggy, (Caplin-Haynes-Houser) 981
Natural and Acquired Immunity to Cancer (Hadley) 464

Obesity, Effective Office Management of, (Allen) 1101
Open Heart Surgery, Masked Hypovolemia Following, (Stein-Knoebel) 231
Open Heart Surgery, Medical Problems After, (Stein-Knoebel) 205
Ovulation Induction with Clomiphene Citrate (Echt-Goodman) 986

Pacemaker Electrocardiography (Fisch) 193
Pericardiectomy in Patients with Nonconstrictive Pericarditis (Siderys-Johnson-Pittman) 330
Pericarditis, Nonconstrictive, Pericardiectomy in Patients with, (Siderys-Johnson-Pittman) 330
PKU Screening, Six Years of Newborn, (Martin) 1107
Polyps, Mucous Nasal, Can Be Managed Non-Surgically, (Rubin) 325
Principles of Therapy in Angina Pectoris (Elliott) 185
Psychotherapy, Some Contributions of Communication Theory to, (Donahue) 1540

Radiotherapy of Hodgkin's Disease (Scott) 459
Rheumatoid Hand, Surgery of the, (Raber-Kleinert) 41
Routine Vaginal Examination of the Intrapartum Patient (Graham) 610

Significance of the Pale, Boggy, Nasal Mucosa (Caplin-Haynes-Houser) 981
Six Years of Newborn PKU Screening (Martin) 1107
Some Apparently Common Problems in Patients Taking "The Pill" (Ball) 61

Some Contributions of Communication Theory to Psychotherapy (Donahue) 1540
Splenic Cyst (Gitlin-Gitlin) 35
Supersonic Transportation, Commercial, and the Patient (Stonehill-Murray) 1645
Surgery of the Rheumatoid Hand (Raber-Kleinert) 41
The Case for Periodic Cancer Detection Examinations (Gilbertsen) 468
The Case of Sanguinous Sanctity (Lieberman) 1434
The Case of the Martial Maquisard (Lieberman) 624
The Case of Perpetual, Poignant Penance (Lieberman) 338
The Evaluation of the Cardiopulmonary Patient for Air Travel (Stonehill-Murray) 1531
The Incidence of Congenital Heart Disease in Adults at the Indiana University Medical Center (Nasser-Feigenbaum-Fisch) 225
The "Luck" of an Injury Repair (Harger) 333
The Management of Depressive States (Nurnberger) 1416
The Management of Hand Injuries (Wray) 486
"The Pill," Some Apparently Common Problems in Patients Taking the, (Ball) 61
The Surgical Treatment of Acute Cholecystitis (Berman-Kimble) 733
The Treatment of Multiple Sclerosis with Intrathecally Administered Methylprednisolone Acetate (Ringer) 1213
Tornado and Automobile Accident Victims, Infections Encountered in, (Ivy) 1657
Treatment of Epilepsy (Green) 1118
Treatment of the Exudative Tonsillar Phase of Infectious Mononucleosis with Oral Enzymes (Roller) 1411
Urinary Infections, Use and Abuse of Antibacterials in, (Garrett) 612
Use and Abuse of Antibacterials in Urinary Infections (Garrett) 612
Vaginal Examination, Routine, of the Intrapartum Patient (Graham) 610
What Constitutes Legal Death (Green) 1120

ELECTROCARDIOGRAM OF THE MONTH

Aberrancy of Intraventricular Conduction Due to "Critical Condition" (Fisch) 495
Arrhythmia Due to Hypoxia (Fisch) 345
Atrioventricular (A-V) Nodal Tachycardia in Emphysema (Fisch) 65
Concealed Digitalis Toxicity (Fisch) 1443
Nonparoxysmal Ventricular Tachycardia (Fisch) 1543
PAT with Block Due to Digitalis (Fisch) 1662
T Wave Abnormalities (Fisch)
Pt. 1 1023
Pt. 2 1133
Pt. 3 1222
Ventricular Synchronized Pacemaker (Fisch) 629

FRACTURES AND ORTHOPEDIC PROBLEMS

Carpal Tunnel Syndrome, Failure of Surgery (Stark) 1547
Case of the "Unhealing" Fracture (Throop) 633
Conserving Surgical Treatment of Rheumatoid Arthritis of the Hands (Brueckmann) 66
Pseudo-pseudohypoparathyroidism (Rapp-Tillema) 498
The Fingertip Injury—An Evaluation of Treatment (Strickland) 1136

PATH-FINDER

Bone Marrow Examinations: Why, When and How? (Blum) 1551
Differential Diagnosis of the Month: Increased CO_2 Content (Palmer) 350
Pre-diabetic Glucose Tolerance Curve (Palmer) 1451
What's Your Diagnosis? (Loh) 1024

THE CANCER YOU VIEW

Pt. 1 (Gosman) 77
Pt. 2 (Thomas) 502
Pt. 3 (Grayson) 636
Pt. 4 (Pantzer) 1026

X-RAY CONFERENCE

Aneurysm of the Abdominal Aorta (Lang) 1134
Arteriographic Diagnosis of Mass Lesions of the Thyroid (Lang) 488
Bicornuate Uterus with Hypoplasia of Right Anlage (Lang) 1013
Blastomycosis Osteomyelitis (Greer-Lang) 1227
Changes of the Diploic Space Secondary to Anemias Mimicking Intracranial Lesions on Technetium Scintiscanograms (Sewell-Lang) 1446
Collateral Circulation from the External to the Internal Carotid System (Lang) 348
Diagnosis of Metastatic Disease to the Obturator Nodes in Carcinoma of the Cervix (Lang) 1664
Dissecting Aneurysm of the Descending Thoracic Aorta (Lang) 1544
Primary Carcinoma of the Ureter (Lang) 80
Stricture of the Membraneous Portion of the Urethra and False Passage (Lang) 630

EDITORIALS

22nd AMA Clinical Convention 1454
"a Disese cald Milksick" (Snively) 1143
AMA Adopts Expanded Statement of Purpose (Guest) 237
AMA Volunteer Physicians for Viet Nam (Guest) 90
Are You Safe At Home? (Guest) 1455
Army MUST System Improves 1454
Are We Well Fed? Who Knows? 1142
Charge to Interns (Stephens) 1231
Chloromycetin, Revised Warnings on, ... 738
Comprehensive Health Planning Seminar Goals and Objectives (Larson) 645
Diabetic, The Undiagnosed, ... 1230
Fifty-Year Club Response (Ritchey) 1667
FLEX (Guest) 1231

Generic Politicians (Guest) 1232
Indiana School and Community Health Workshop 1028
ISMA Commission on Voluntary Health Agencies 738
Medical Ethics (Guest) 1668
Nation of the Physically Unfit (Nicholson) 1144
New Method Tried in Personal Injury Suits 1554
Noncommercial Aspects of Medical Advertising (Guest) ... 512
No Sounding Brass at Roche (Guest) 353
Partners of the Alliance 1666
People Problem vs. Food Problem 511
Pharmaceutical Industry Research 1028
Pharmaceutical Research 236
Plastic Surgery: Reconstructive or Cosmetic? (Bennett) .. 1029
PMA Comments on Second Report of HEW Task Force ... 1554
Recommendations for Comprehensive Health Planning (as presented at the Comprehensive Health Planning Seminar, March 31, 1968) 646
Revised Warnings on Chloromycetin 738
School-bus Safety 88
Second Interim Report of the HEW Task Force on Prescription Drugs 1666
Socio-Economic Education of Physicians 236
Stricter Drug Legislation 739
The Cheerful Doctor (Guest) 89
The Chicago Convention and Socialized Medicine (Guest) .. 1668
The Kirkpatrick Workshop 646
The Markle Foundation 88
The Promised Second Misconception (Hickman) 1455
The Secretary's Misconception (Hickman) 1230
The Successful Disaster Plan 353
The Undiagnosed Diabetic 1230
Two Mailings (Hickman) 1142
Venereal Disease Problem (Marshall) 1144

SPECIAL FEATURES

AMA House of Delegates, Report on Actions of the, (21st Clinical Convention, Nov. 26-29, 1967, Houston, Tex.) ... 113
AMA House of Delegates, Report on Actions of the, (117th Annual Convention, June 16-20, 1968, San Francisco, Calif.) 1156
An Introduction to the Children's Pavilion of Methodist Hospital 666
Aspirin (Stevenson) 1462
Dean's Report: 1966-67 Report from the I.U. School of Medicine (Irwin) 102
Federally Approved Home Health Services Agencies in Indiana 751
Heart—Cancer—Stroke; Indiana Regional Program (Stonehill) 521
ISMA Annual Reception for Indiana Delegation in Congress Also Honors Charlie Halleck 670
ISMA Preceptor Program Described 530
Is There A Challenge? (Annis) 656
Local Board of Health Services—Today and Tomorrow (Maris) 146
Medicare Approved Independent Clinical Laboratories 75
Meet The Journal Staff Part 6 9
New Zoning Ordinance Creates Hospital Districts 167
Orient Medical Tour (Loh) 129
Personal Observations of Medicine and Surgery in Indiana (Link) 25
P. J. V. Corcoran, M.D., President, 1968-69 155
Psychiatric Evidence Needed in Social Security Disability Evaluation (Nussbaum-Schneidmuhl-Shaffer) 37
Report on Actions of the AMA House of Delegates (21st Clinical Convention, Nov. 26-29, 1967, Houston, Tex.) 11
Report on Actions of the House of Delegates, (AMA 117th Annual Convention, June 16-20, 1968, San Francisco, Calif.) (Bush) 115
Tax Status of Partnerships Under the Indiana Adjusted Gross Income Tax Act 153
The New State Board Examination (Alcorn) 130
The New State Board Examination (Alcorn) 156
The Physician and the National Library of Medicine (Karel) 147
The Social Security Disability Program (Haggard) 156
The Sophist Society (Blazey) 103
The S. S. HOPE—A Modern Medical Center (Baptisti) ... 128
The Tiny Flaws in Medical Design Can Kill (Gechman) 115
Traffic Deaths in Lake County: 1966 (Loh-Williams) 10

REGULAR FEATURES

About Our Cover 64, 200, 417, 510, 601, 990, 1108, 1215, 1418, 1552, 1632
Abstracts, Book Reviews 135, 272, 392, 540, 688, 1052, 1163, 1311, 1481, 1585, 1682
Annual Meeting Dates of Professional Medical and Allied Organizations 143, 275, 409, 550, 680, 1061, 1175, 1349, 1491, 1603, 1699
Blue Shield Series:
20 Years of Service 139
Computers Speed Blue Shield Claims Processing 262
Blue Cross and Blue Shield Improve Medicare Supplement Benefits 381
Blue Shield Operational Data: 1946-1967 532
1967 Record Year for Blue Cross-Blue Shield 673
Your Blue Shield Board of Directors 726
Changes in Blue Shield Payment Patterns 1049
Blue Cross and Blue Shield Return Most in Benefits 1166
New Blue Shield National Account ID Card 1318
More Protection for Blue Shield Members 1477
What Is the Blue Shield "Usual and Customary" Program? 1580
Blue Shield Report to ISMA House of Delegates 1678
Board of Health Report 146, 278, 412, 552, 680, 896, 1066, 1174, 1340, 1492, 1584, 1680
County, District News 149, 292, 414, 560, 703, 1064, 1604, 1700
Day by Day with the FDA 132, 1038, 1302, 1475

Editorial Notes 90, 237, 354, 512, 647, 739, 1030, 1144, 1232, 1456, 1555, 1668

Fourth Estate 22, 179, 318, 450, 598, 724, 972, 1200, 1391, 1527, 1640

From The Journal 50 Years Ago 28, 281, 402, 457, 678, 728, 1056, 1119, 1228, 1398, 1542, 1692

Future Meetings, Seminars, Courses 147, 289, 404, 558, 700, 1062, 1176, 1342, 1493, 1605, 1681

Gleaned from the British Medical Journal (Hickman) 374, 1154, 1294, 1476, 1573

Letters to the Editor 18, 452, 594, 978, 1384, 1638

Medical Panorama:
- Thanatology Resurrected (Cavins) 1159
- A Separate Department of Health? (Cavins) 1473
- Generic Prescription Writing (Cavins) 1582

Medicine At Law 126, 267, 384, 534, 682, 1040, 1160, 1306, 1478, 1574, 1674

Month in Washington 14, 170, 308, 442, 580, 966, 1096, 1204, 1380, 1516, 1628

News from Indiana University School of Medicine 120, 260, 376, 528, 672, 1474

News Notes 140, 284, 397, 544, 694, 1058, 1169, 1331, 1485, 1594, 1686

President's Page
(Larson) 94, 247, 361, 513, 648, 742, 1032, 1146, 1233, 1458

President's Page
(Corcoran) 1558, 1625

The Woman's Auxiliary Reports to ISMA
(Deever) 101, 250, 364, 516
(Kephart) 654, 744, 1034, 1148, 1234, 1563

Wanted: Physicians, Locations 142, 532, 673, 1049, 1166, 1324, 1477, 1672

What's New? 21, 178, 317, 449, 591, 731, 965, 1093, 1197, 1377, 1513, 1637

CONVENTION ISSUE

Announcement 1235

Convention Arrangements Committees 1256

Fifty-Year Club. 1241

House of Delegates 1238

House of Delegates, Official Call to the, ... 1237

Officers of ISMA, 1967-1968 1241

Officers of ISMA (pictures) 1242

Program, 119th Annual Convention 1249

Reference Committees 1241

Reports of Commissions 1271

Reports of Committees 1268

Reports of Officers 1257

Resolutions 1278

Scientific Exhibits 1282

Section Officers 1245

Technical Exhibitors 1285

Woman's Auxiliary Program 1256

1968 CONVENTION

1910 Physician's Office Highlight of Fort Wayne (Stahl) .. 1701

1968—The Convention Story 1722

Convention Election Results: Dr. Lowell H. Steen is Named President-Elect 1724

The Winners 1725

American Medicine Leads the Way (Wilbur) 1726

ASSOCIATION BUSINESS

Executive Committee:
- Nov. 18, 1967 150
- Jan. 13, 1968 416
- Mar. 6, 1968 705
- Apr. 7, 1968 1068
- May 18, 1968 1178
- June 8, 1968 1179
- July 20, 1968 1352
- Aug. 17, 1968 1496
- Sept. 19, 1968 1608
- Oct. 14, 1968 1730
- Oct. 18, 1968 1731

The Council:
- Jan. 14, 1968 418
- Mar. 8, 1968 1069
- June 9, 1968 1180
- May 18 and 19, 1968 1354
- Aug. 17, 1968 1731
- Aug. 18, 1968 1739
- Oct. 14, 1968 1748
- Oct. 18, 1968 1754

YEARBOOK SECTION

Approved Hospitals in Indiana 886

Approved Mental Hospitals 894

Class A Narcotic Drugs 924

Community Centers for the Mentally Retarded 874

Constitution and Bylaws of the ISMA 932

Deaths of Indiana Physicians in 1967 927

Disease Prevention by Immunization and Chemoprophylaxis 918

Indiana Accredited Practical Nursing Schools 872

Indiana Accredited Schools of Professional Nursing 870

I.U. School of Medicine, Heads of Departments 885

Licensed Nursing Homes in Indiana 897

Membership Roster
- Alphabetically 1/757
- By Counties 33/789
- Woman's Auxiliary 71/827

Outpatient Mental Health Facilities in the State of Indiana: 1968 908

Poison Control Centers in Indiana and Adjacent States 914

Presidents of ISMA Since Its Organization 930

Professional Medical and Allied Organizations 880

Principles of Medical Ethics of the American Medical Association 948

State Elected Officials 860
State Health Organizations 862
Voluntary Organizations 884

AUTHORS

Alcorn, Merritt O., M.D., (The New State Board Examination) 1300
Alcorn, Merritt O., M.D., (The New State Board Examination) 1566
Allen, George S., M.D., (Effective Office Management of Obesity) 1101
Annis, Edward R., M.D., (Is There A Challenge?) 656
Ball, Philip, M.D., (Some Apparently Common Problems in Patients Taking "The Pill") 61
Baptisti, Arthur, Jr., M.D., (The S. S. HOPE—A Modern Medical Center) 1288
Behnke, Roy H., M.D., (Clinicopathologic Conference) 1423
Bennett, James E., M.D., (Plastic Surgery: Reconstructive or Cosmetic?) 1029
Berman, Jacob K., M.D., (The Surgical Treatment of Acute Cholecystitis) 733
Blazey, Arthur G., M.D., (The Sophist Society) 1036
Blum, Leon L., M.D., (Bone Marrow Examinations: Why, When and How?) 1551
Bolinger, Garry L., M.D., (Clinicopathologic Conference) .. 1002
Brueckmann, F. Robert, M.D., (Conserving Surgical Treatment of Rheumatoid Arthritis of the Hands) 66
Bush, Kenneth W., (Report on Actions of the AMA House of Delegates, 117th Annual Convention, June 16-20, 1968, San Francisco, Calif.) 1156
Caplin, Irvin, M.D., (Significance of the Pale, Boggy Nasal Mucosa) 981
Carlson, Edith, M. T. (ASCP), (Comparison of the Mono Test and the Heterophile Antibody Test) 984
Cavins, A. W., M.D., (A Separate Department of Health?) .. 1473
Cavins, A. W., M.D., (Endometriosis in Case of Primary Hypogonadism) 996
Cavins, A. W., M.D., (Generic Prescription Writing) 1582
Cavins, A. W., M.D., (Thanatology Resurrected) 1159
Dennison, A. D., Jr., M.D., (Cardiogenic Shock in Acute Myocardial Infarction) 1537
Donahue, James M., M.D., (Some Contributions of Communication Theory to Psychotherapy) 1540
Echt, Charles R., M.D., (Ovulation Induction with Clomiphene Citrate) 986
Elliott, William C., M.D., (Principles of Therapy in Angina Pectoris) 185
Feigenbaum, Harvey, M.D., (The Incidence of Congenital Heart Disease in Adults at the Indiana University Medical Center) 225
Fisch, Charles, M.D., (Aberrancy of Intraventricular Conduction Due to "Critical Condition") 495
Fisch, Charles, M.D., (Arrhythmia Due to Hypoxia) 345
Fisch, Charles, M.D., (Atrioventricular (A-V) Nodal Tachycardia in Emphysema) 65
Fisch, Charles, M.D., (Clinicopathologic Conference) 100
Fisch, Charles, M.D., (Concealed Digitalis Toxicity) 144
Fisch, Charles, M.D., (Nonparoxysmal Ventricular Tachycardia) 154
Fisch, Charles, M.D., (Pacemaker Electrocardiography) 19
Fisch, Charles, M.D., (PAT With Block Due to Digitalis) .. 166
Fisch, Charles, M.D., (The Incidence of Congenital Heart Disease in Adults at the Indiana University Medical Center) 22
Fisch, Charles, M.D., (T Wave Abnormalities)
Pt. 1 1023
Pt. 2 1133
Pt. 3 1222
Fisch, Charles, M.D., (Ventricular Synchronized Pacemaker) 629
Garrett, Robert A., M.D., (Use and Abuse of Antibacterials in Urinary Infections) 612
Gechman, Ronald, (The Tiny Flaws in Medical Design Can Kill) 1151
Gilbertsen, Victor A., M.D., (The Case for Periodic Cancer Detection Examinations) 468
Gitlin, Max M., M.D., (Splenic Cyst) 35
Gitlin, William A., M.D., (Splenic Cyst) 35
Glover, John L., M.D., (Arterial Lesions Due to Blunt Trauma) 1403
Goodman, Jerry A., A.B., (Ovulation Induction with Clomiphene Citrate) 986
Gosman, James H., M.D., (The Cancer You View) 77
Graham, William E., M.D., (Routine Vaginal Examination of the Intrapartum Patient) 610
Grayson, Ted L., M.D., (The Cancer You View) 636
Green, John C., B.S., (What Constitutes Legal Death) 1120
Green, Joseph B., M.D., (Treatment of Epilepsy) 1118
Green, Robert F., M.D., (An Evaluation of the Psychological Aspects of Dropouts) 1216
Greer, John L., M.D., (Blastomycosis Osteomyelitis) 1227
Hackney, Victor C., M.D., (Management of Acne Vulgaris) 1000
Hadley, Henry G., M.D., (Natural and Acquired Immunity to Cancer) 464
Haggard, E. B., M.D., (The Social Security Disability Program) 1564
Harger, Robert Wm., M.D., (The "Luck" of an Injury Repair) 333
Haynes, John T., M.D., (Significance of the Pale, Boggy Nasal Mucosa) 981
Hickman, Jack W., M.D., (Five Year's Experience with Dymelor) 1114
Hickman, Jack W., M.D., (The Promised Second Misconception) 1455
Hickman, Jack W., M.D., (The Secretary's Misconception) 1230
Hickman, Jack W., M.D., (Two Mailings) 1142
Hubbard, Jesse D., M.D., (Clinicopathologic Conference) .. 53
Houser, Duane, M.D., (Significance of the Pale, Boggy Nasal Mucosa) 981
Irwin, Glenn W., Jr., M.D., (Dean's Report: 1966-67 Report from the I.U. School of Medicine) 102
Ivy, John H., M.D., (Infections Encountered in Tornado and Automobile Accident Victims) 1657

Johnson, Cedric, M.D., (Pericardiectomy in Patients with Nonconstrictive Pericarditis) 330

Jarel, Leonard, Ph.D., (The Physician and the National Library of Medicine) 1470

Kimble, John W., M.D., (The Surgical Treatment of Acute Cholecystitis) 733

King, Harold, M.D., (Arterial Lesions Due to Blunt Trauma) 1403

Kirtley, William R., M.D., (Five Year's Experience with Dymelor) 1114

Kleinert, Harold E., M.D., (Surgery of the Rheumatoid Hand) 41

Kleit, Stuart, M.D., (Clinicopathologic Conference) 614

Knoebel, Suzanne B., M.D., (Masked Hypovolemia Following Open Heart Surgery) 231

Knoebel, Suzanne B., M.D., (Medical Problems After Open Heart Surgery) 205

Lang, Erich K., M.D., (Aneurysm of the Abdominal Aorta) 1134

Lang, Erich K., M.D., (Arteriographic Diagnosis of Mass Lesions of the Thyroid) 488

Lang, Erich K., M.D., (Bicornuate Uterus with Hypoplasia of Right Anlage) 1013

Lang, Erich K., M.D., (Blastomycosis Osteomyelitis) 1227

Lang, Erich K., M.D., (Changes of the Diploic Space Secondary to Anemias Mimicking Intracranial Lesions on Technetium Scintiscanograms) 1446

Lang, Erich K., M.D., (Collateral Circulation from the External to the Internal Carotid System) 348

Lang, Erich K., M.D., (Diagnosis of Metastatic Disease to the Obturator Nodes in Carcinoma of the Cervix) 1664

Lang, Erich K., M.D., (Dissecting Aneurysm of the Descending Thoracic Aorta) 1544

Lang, Erich K., M.D., (Primary Carcinoma of the Ureter) .. 80

Lang, Erich K., M.D., (Stricture of the Membraneous Portion of the Urethra and False Passage) 630

Larson, G. O., M.D., (Comprehensive Health Planning Seminar Goals and Objectives) 645

Lieberman, Arnold, M.D., (The Case of the Martial Maquisard) 624

Lieberman, Arnold, M.D., (The Case of Perpetual, Poignant Penance) 338

Lieberman, Arnold, M.D., (The Case of Sanguinous Sanctity) 1434

Link, Goethe, M.D., (Personal Observations of Medicine and Surgery in Indiana) 252

Loh, Wei-Ping, M.D., (A New Solubility Test for Rapid Detection of Hemoglobin S) 1651

Loh, Wei-Ping, M.D., (Drug-Induced Blood Dyscrasias) ... 1125

Loh, Wei-Ping, MD., (Orient Medical Tour) 1292

Loh, Wei-Ping, M.D., (Traffic Deaths in Lake County: 1966) 106

Loh, Wei-Ping, M.D., (What's Your Diagnosis?) 1024

Maris, Lee J., M.D., (Local Board of Health Services—Today and Tomorrow) 1466

Marshall, A. L., Jr., M.D., (Venereal Disease Problem) 1144

Martin, Paul H., M.D., (Six Years of Newborn PKU Screening) 1107

Miller, Roscoe, M.D., (Clinicopathologic Conference) 53

Miller, Roscoe, M.D., (Clinicopathologic Conference) 475

Miller, Roscoe, M.D., (Clinicopathologic Conference) 614

Miller, Roscoe, M.D., (Clinicopathologic Conference) 1423

Murray, Raymond H., M.D., (Commercial Supersonic Transportation and the Patient) 1645

Murray, Raymond H., M.D., (Medical Considerations for Patients in Commercial Air Travel) 1395

Murray, Raymond H., M.D., (The Evaluation of the Cardiopulmonary Patient for Air Travel) 1531

Nasser, William K., M.D., (The Incidence of Congenital Heart Disease in Adults at the Indiana University Medical Center) 225

Nicholson, V. L., (Nation of the Physically Unfit) 1144

Nurnberger, John I., M.D., (The Management of Depressive States) 1416

Nussbaum, Kurt, M.D., (Psychiatric Evidence Needed in Social Security Disability Evaluation) 370

Palmer, H. P., M.D., (Increased $C0_2$ Content) 350

Palmer, H. P., M.D., (Pre-diabetic Glucose Tolerance Curve) 1451

Pantzer, John G., M.D., (The Cancer You View) 1026

Petty, Charles, M.D., (Clinicopathologic Conference) 1423

Pittman, John, M.D., (Pericardiectomy in Patients with Nonconstrictive Pericarditis) 330

Raber, Robert M., M.D., (Surgery of the Rheumatoid Hand) 41

Rapp, George F., M.D., (Pseudo-pseudohypoparathyroidism) 498

Ricchetti, W. F., M.D., (Comparison of the Mono Test and the Heterophile Antibody Test) 984

Ringer, William A., M.D., (The Treatment of Multiple Sclerosis with Intrathecally Administered Methylprednisolone Acetate 1213

Ritchey, J. O., M.D., (Fifty-Year Club Response) 1667

Roller, Mac C., M.D., (Treatment of the Exudative Tonsillar Phase of Infectious Mononucleosis with Oral Enzymes) .. 1411

Rubin, Simon S., M.D., (Mucous Nasal Polyps Can Be Managed Non-Surgically) 325

Russell, H. T., M.D., (Comparison of the Mono Test and the Heterophile Antibody Test) 984

Scott, Ralph M., M.D., (Radiotherapy of Hodgkin's Disease) 459

Schneidmuhl, Abraham M., M.D., (Psychiatric Evidence Needed in Social Security Disability Evaluation) 370

Sewell, Patrick E., M.D., (Changes of the Diploic Space Secondary to Anemias Mimicking Intracranial Lesions on Technetium Scintiscanograms) 1446

Shaffer, John W., Ph.D., (Psychiatric Evidence Needed in Social Security Disability Evaluation) 370

Shumacker, Harris B Jr., M.D., (Coarctation of the Aorta) .. 334

Siderys, Harry, M.D., (Pericardiectomy in Patients with Nonconstrictive Pericarditis) 330

Snively, W. D., Jr., M.D., ("a Disese cald Milksick") 1143

Stahl, Jackie (1910 Physician's Office Highlight of Fort Wayne) 1722

Stark, William A., M.D., (Carpal Tunnel Syndrome, Failure of Surgery) 1547

Stein, Leon, M.D., (Masked Hypovolemia Following Open Heart Surgery) 231

Stein, Leon, M.D., (Medical Problems After Open Heart Surgery) 205

Steinmetz, Edward, M.D., (Clinicopathologic Conference) .. 475

Stephens, Donald E., M.D., (Charge to Interns) 1231
Stevenson, Jessie M., (Aspirin) 1462
Stonehill, Robert B., M.D., (Commercial Supersonic Transportation and the Patient) 1645
Stonehill, Robert B., M.D., (Heart—Cancer—Stroke; Indiana Regional Program) 521
Stonehill, Robert B., M.D., (Medical Considerations for Patients in Commercial Air Travel) 1395
Stonehill, Robert B., M.D., (The Evaluation of the Cardiopulmonary Patient for Air Travel) 1531
Strickland, James W., M.D., (The Fingertip Injury—An Evaluation of Treatment) 1136

Tavel, Morton E., M.D., (Gallop Rhythm of the Heart: Current Concepts) 208
Telle, J. Thomas, M.D., (Idiopathic Neonatal Gastric Perforation: Report of Six Cases) 602
Thomas, Charles R., M.D., (The Cancer You View) 502
Throop, Frank B., M.D., (Case of the "Unhealing" Fracture) 633
Tillema, David, M.D., (Pseudo-pseudohypoparathyroidism) 498

Vellios, Frank, M.D., (Clinicopathologic Conference) 1002

Waltz, Charles A., M.D., (Arterial Lesions Due to Blunt Trauma) 1403
White, Arthur C., M.D., (Clinicopathologic Conference) ... 53
Wilbur, Dwight L., M.D., (American Medicine Leads the Way) 1726
Wilens, Sigmund L., M.D., (Clinicopathologic Conference) 475
Wilens, Sigmund L., M.D., (Clinicopathologic Conference) 614
Williams, Alexander S., M.D., (Traffic Deaths in Lake County: 1966) 106
Wray, James B., M.D., (The Management of Hand Injuries) 486

DEATHS

Acker, Robert B., M.D., South Bend 1350
Adair, Samuel L., M.D., Jeffersonville 1177
Ash, H. Herman, M.D., West Lafayette 704
Ayres, Kenneth D., M.D., Anderson 1065

Bacevich, Andrew J., M.D., Hammond 704
Banks, Horace M., M.D., Indianapolis 1698
Benages, Anthony G., M.D., Jasper 1065
Brady, Samuel J., M.D., Gary 704
Bruner, Ralph W., M.D., Jeffersonville 704

Carlyle, Ivan E., M.D., Michigantown 1177
Conforti, Victor P., M.D., Terre Haute (formerly) 408
Cook, Charles E., M.D., North Manchester 1350
Craig, Reuben A., M.D., Kokomo 292
Crockett, Franklin S., M.D., Lafayette 408
Dickens, Karl L., M.D., Indianapolis 292
Dutchess, C. Toney, M.D., Galveston 1065

Emhardt, John W. A., M.D., Indianapolis 1698

Fisher, John E., M.D., Attica 704
Fisher, William C., M.D., Evansville 408
Foltz, Lloyd E., M.D., Brownsburg 408

Harrington, James F., M.D., Logansport 1065
Headley, Lloyd M., M.D., Lebanon 1065
Helman, Harry W., M.D., Rolling Prairie 1065
Hippensteel, Russell R., M.D., Indianapolis (formerly) 1495
Hoffman, Doris, M.D., Vincennes (formerly) 1350
Holmes, Claude, M.D., Frankfort (formerly) 704
Hostetler, Carl M., M.D., Goshen 1698
Hudson, Foster J., M.D., Indianapolis 292

Kielton, Melvyn J., M.D., Elkhart 1177
Kime, Edwin E., M.D., Indianapolis (formerly) 1495
Kistler, James J., M.D., LaPorte 1698

Lewis, Robert J., M.D., Indianapolis 1350

McDonald, Ralph M., M.D., South Bend (formerly) 704
McGuire, Desmond F., M.D., East Chicago 1177
McIntyre, Charles J., M.D., Indianapolis 1698
Magennis, Herbert J., M.D., Indianapolis 292
Mauricio, Amado S. A., M.D., Rising Sun 1350
May, William D., M.D., New Albany 1350

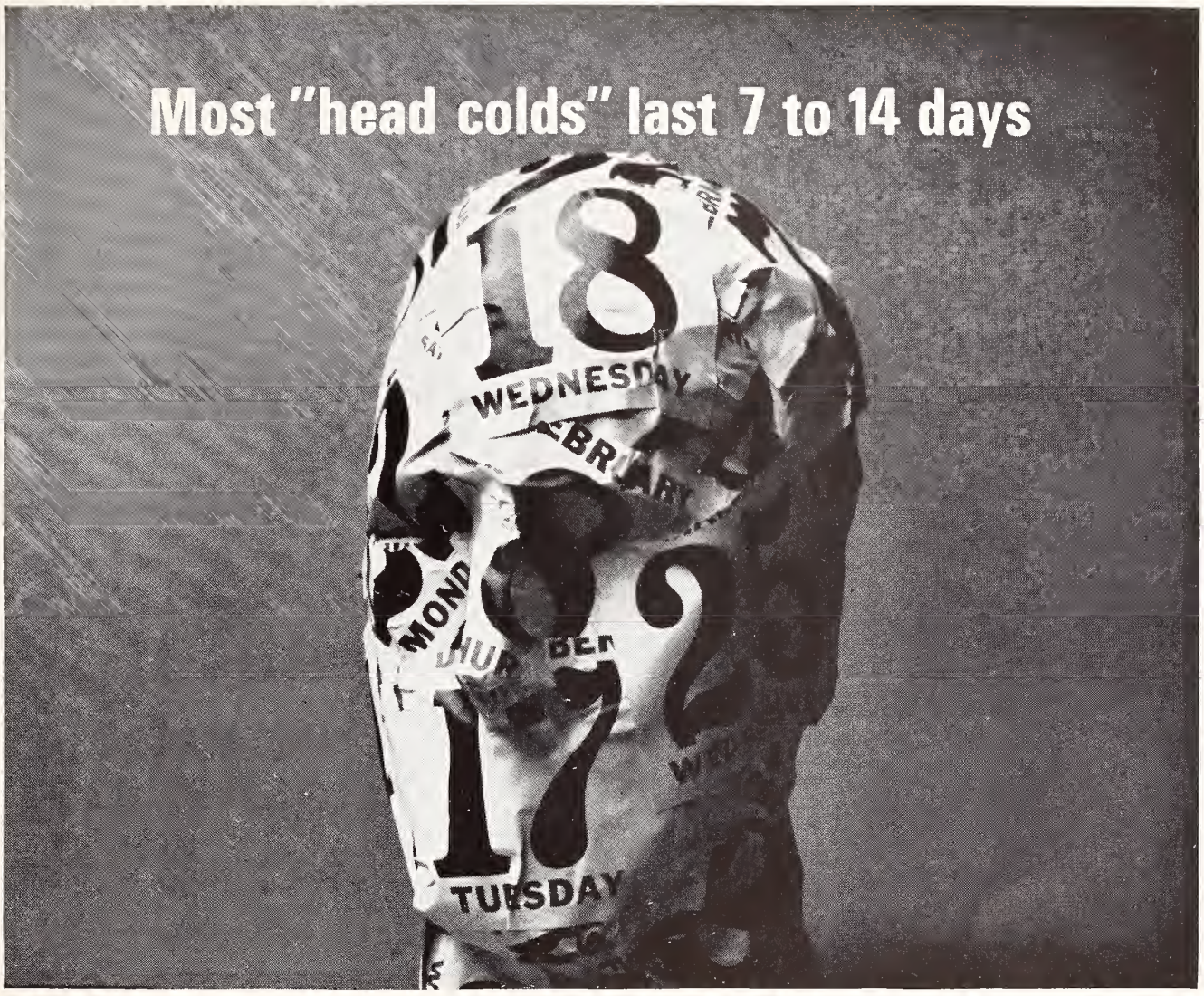
Owen, R. Wynn S., M.D., Indianapolis (formerly) 1065

Reilly, James F., M.D., Vincennes 1065
Richardson, Thad T., M.D., Indianapolis 408
Richie, Richard F., M.D., Westville (formerly) 1698

Sacks, Leonard Z., M.D., Valparaiso 1495
Sarver, Francis E., M.D., Fort Wayne 1065
Savage, Arthur R., M.D., Fort Wayne 1065
Senese, Thomas J., M.D., Gary 1350
Shullenberger, Wendell A., M.D., Indianapolis 1495
Skeen, Earl D., M.D., South Bend 1177
Smith, Herbert N., M.D., Brookville 292
Stewart, Walter E., M.D., Terre Haute 1698
Stover, Wendell C., M.D., Boonville 1495

Urschel, Dan L., M.D., Mentone 704

Weiss, Henry G., M.D., Evansville 1350
Wilber, H. R., M.D., Jeffersonville (formerly) 1177
Wynn, Justice F., M.D., Evansville 408



In the meantime...Ornade®

Prompt relief from nasal congestion and hypersecretion due to colds.

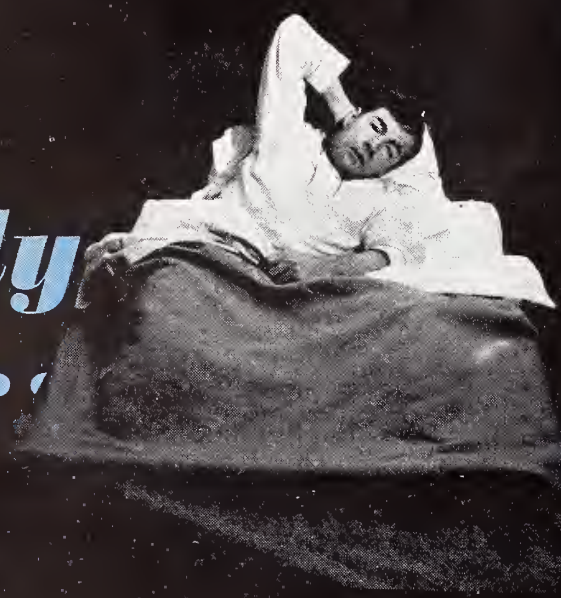
Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.
Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.
Usage in Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.
Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.
Supplied: Bottles of 50 capsules.

One capsule q12h for round-the-clock relief

Ornade® Trademark Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide.
Spansule® capsules brand of sustained release capsules

SK&F Smith Kline & French Laboratories

ready for bed...



...but not for sleep

...because psychic tension may not stop at night

The calming action of Valium (diazepam) helps counteract psychic tension and reduce overreaction to stresses during the day. Often the t.i.d. dosage schedule is enough to prevent build-up of tenseness that may interfere with sleep at night.

However, when psychic tension does contribute to sleeplessness, Valium can be especially useful. A tablet at bedtime, added to the daytime t.i.d. dosage, can help your patient be ready for bed *and* for sleep.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium®
(diazepam)

ROCHE

Roche®
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

THE LIBRARY
UNIVERSITY OF CALIFORNIA
San Francisco
THIS BOOK IS DUE ON THE LAST DATE STAMPED BELOW

7 DAY LOAN

7 DAY
DEC 1 - 1970
RETURNED
NOV 27 1970
7 DAY
JUN 6 1973
RETURNED
JUN - 1 1973

15m-5,'70(N6490s4)4315-A33-9

St

224866